The Journal of the American Medical Association

Published Under the Auspices of the Board of Trustees

VOL. LXI, No. 26 CHICAGO, ILLINOIS DECEMBER 27, 1913

CONTROL OF CANCER*

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We now have evidence to show that the number of cures of cancer can be increased. No one will question that cancer of the lip, tongue, skin, stomach and colon has been cured by radical excision. There was a time in the history of surgery when no such cures had been accomplished. In 1890, Agnew, professor of surgery at the University of Pennsylvania, made the public statement in his surgical clinic that he had never cured a patient of cancer of the breast. Within a few weeks I have seen a patient operated on for cancer of the breast by Dr. Halsted in 1890, who is still living and apparently as free from signs of cancer as a person who had never suffered from that disease.

Agnew, who honestly stated that he had never cured cancer, only removed the breast and never operated, except when the signs of cancer were fully developed. Halsted, in 1890, removed not only the breast, but a wide area of skin, both pectoral muscles and the axillary contents *en bloc*. Halsted also operated the moment he was given the opportunity.

When the first statistical study from the Johns Hopkins Hospital was published, showing 47 per cent. of patients apparently free from cancer three years after operation, most surgeons in this country were skeptical as to the truth of these statistics. Every few years a reinvestigation of the results confirms the original statement.

The number of cures of cancer can be increased by earlier intervention and better surgery. The American Society for the Control of Cancer hopes to bring before the public and the profession the actual percentage of cures of cancer accomplished in the various clinics in this country. In these clinics complete records have been kept; in each case the diagnosis has been checked by competent pathologic examination, and in many instances the original tissues and microscopic sections have been preserved for restudy—therefore, for a confirmation of the original diagnosis.

Many physicans to-day are skeptical as to the permanency of the cure of cancer. They question the pathologic diagnosis in the cases in which the patients have lived ten years or more. In the clinics just referred to, in which the records and the tissues have been preserved, the histologic picture of the tumor in the case of a cure does not differ from the histologic picture of the case or cases in which the patients later died of cancer. When, therefore, we have for every case in which the patient was cured a histologically identical case in which the patient was not cured, it is fair to assume that the patient cured also suffered from cancer.

The majority of people believe that cancer is a "blood disease." By this they express a vague notion of a general disease present in many parts of the body, and for this reason they naturally conclude that its removal from one place will have no effect on the disease in other parts.

The majority of surgeons who operate for cancer do not always tell their patients the nature of the disease, but, whether they do or not, the longer the patient lives in comfort the more skeptical does he or she become as to the grave nature of the original disease. Especially, is this true in cases in which the operation was necessarily mutilating, as in skin-grafting in operations for cancer of the breast, or in resection of the jaw in cancer of the tongue and gum, or in some cases of amputation for carcinoma or sarcoma of the extremities. Again and again, in the course of my investigation of the ultimate results in malignant disease, I have encountered in correspondence and conversation the questions: Was it necessary to do so much? Was the disease really cancer?

In the control of cancer, therefore, we shall have to combat this skepticism both in the ranks of the profession and among the people. We have the evidence that cancer can be cured and we must bring it before the profession and the public in such a way that they will believe it.

The percentage of cures in the fully developed cancer is relatively small. The exact figures differ with the localizations. By fully developed cancer I mean one in which there can be no question as to the histologic evidence of malignancy. In this type, too, cures have been accomplished and, while the percentage of these cures is relatively smaller, the possibility of increasing it is by no means out of the question. There is great difference pathologically and clinically between fully developed cancers. A tumor is clinically malignant, or cancerous, when the examining clinician is able to make the diagnosis of the condition without the aid of the gross appearance of the tumor cut with the knife or a microscope section.

When cancer is clinically malignant the probability of a cure is relatively smaller than when it is only histologically malignant, but has not as yet assumed the clinical picture of cancer. This is well illustrated in cancer of the breast. In the Johns Hopkins Hospital surgical clinic, among those cases in which previous to operation a clinical diagnosis of cancer could not be made, the proportion of cures five years after the radical operation is 80 per cent. In these cases the diagnosis was made at the exploratory incision either from the gross appearance of the tumor after it had been cut into or from the frozen section.

* An address delivered before the Lehigh Valley Medical Society, June 17, 1913.

In those cases in which the diagnosis of cancer could be made clinically from the retracted nipple or adherent skin, the proportion of cures after five years is about 25 per cent. It is an important thing to state that there is absolutely no difference in the pathology of the clinically malignant cancer of the breast and the cancer which cannot be distinguished clinically from a benign tumor.

We may divide cancer of the breast into different forms of adenocarcinoma, scirrhus and medullary carcinoma and cancer cysts, and in each group we shall find some cases subjected to the complete operation in that early stage in which the diagnosis could be made only at the exploratory incision and some in that later period when malignancy was written on the condition by changes in the skin and nipple. The same differences in the results are seen in the different types of cancer. One cannot tell with the microscope, unless one has a section near the skin or nipple in which the infiltration of the tumor is shown, whether this cancer was clinically malignant or not. It is the same type of cancer, therefore; yet, in one case the patient has eighty chances to only twenty-five in the other. The two are subjected to the same operation by the same operator, yet the probabilities of a cure are influenced chiefly by this fact: When the cancer is clinically malignant the chances of a cure are worst; when it is clinically benign, best. This fact is true of cancer in every localization, and the truth of this statement must be impressed on the entire profession and the people. The old method of waiting for the signs of cancer simply means decreasing the probability of a cure. The same is true of cancer of the lip, the tongue, the skin of the face, body and extremities, the uterus, stomach, colon, etc. The danger of the length of delay varies with cancers in these different localizations.

We have evidence which suggests that, when the disease is treated before it has become clinically malignant, the number of cures of cancer can be increased far beyond the number of cures already accomplished in cancer.

In every localization in which we encounter cancer, we also meet lesions which, histologically, are not cancer. When these lesions are radically removed we never observe recurrence or death from cancer which could be attributed to the tumor removed. It would hardly be right to call these cases cures of cancer, but, as a matter of fact, the time may come when so many patients present themselves for treatment with tumors or lesions in this stage that we shall at once begin to observe in all clinics a decrease in the numbers of cancer cases. It is possible, therefore, in some localizations of cancer to hope for complete eradication of any uncured cancer. These lesions, which histologically are not cancer and which are curable up to 100 per cent. by radical removal, may be called precancerous.

In external cancer, when the patient is carefully questioned, we can usually obtain a history of the beginning of the disease which later comes under observation as cancer. Among 820 pathologically fully developed cancers of the skin and visible mucous membranes, I was unable to find, in a well-taken history, the absence of a previous defect which might be looked on as a benign precancerous lesion. At present, among 997 epithelial tumors of the skin and visible mucous membranes, 173 have been histologically benign, and there was not a single failure to cure in this latter group. The actual proportion of these lesions has increased from 17 to 39 per cent. in two years. Does this mean that we have actually prevented cancer, or does it simply mean that we have removed warts and benign ulcers which would have disappeared if we had left them alone?

We have not, to-day, the figures to prove that the routine and proper removal of these benign, so-called precancerous lesions will reduce the number of deaths from cancer, but the recent evidence is suggestive. In my investigation of cancers of the skin and mucous membranes the worst results are seen in cancer of the tongue. At present we have records of and tissues from thirteen benign and seventy-one malignant lesions of the tongue. These thirteen benign lesions have all been obtained in the past five years, most of them in the past two years. Until three years ago we had never observed a cancer of the tongue at so early a stage that there was any doubt as to the correct diagnosis, but in the past two years we have had six early cases. Up to the present time we have had about 20 per cent. of cures in cancer of the tongue. The experience of the past two years indicates that the proportion of cures will be increased to 40 per cent. I feel confident that no one should fear cancer of the lip, tongue or skin, if he is only educated to the potential dangers of these precancerous lesions, provided that a person so educated obtains in this stage the advice and treatment of a properly trained surgeon. I also feel confident from my investigation that the number of deaths from cancer of the skin and visible mucous membranes, such as lip, tongue and cheek, will be greatly decreased; more operations will be done for the precancerous lesions with 100 per cent. of cures; more operations will be performed for the histologically fully developed cancer, but in that early stage in which it cannot be diagnosed clinically and in which the probability of a cure, while not 100 per cent., is still best. Fewer operations will be performed for cancer clinically malignant with its relatively low possibility of a cure, and in fewer cases will patients present themselves with inoperable cancer.

In cancer of the stomach, colon, appendix, gall-bladder, pancreas, etc., it is more difficult to demonstrate the precancerous lesion. Is it fair to look on every cured resected ulcer of the stomach as a cured cancer? There is no doubt that the histologically fully developed cancer of the stomach has been cured by pylorectomy. The results have been best when the clinical symptoms have been least and of the shortest duration. When a clinical diagnosis of cancer of the stomach or colon can be made, the probability of a cure is least. Fortunate is the patient with cancer of the stomach or colon whose tumor produces obstruction early, because the symptoms then urge operation. Unfortunate, and, in the majority of cases, doomed, is that patient the symptoms of whose neoplasm are slight.

If it has been difficult to educate people and the profession as to the potential danger of a lump in the breast, small and painless defects of the skin and mucous membranes and irregular bleeding from the uterus, it will be much more difficult to educate them to the significance of abdominal pain, indigestion and changes in the stools. The lump in the breast and the precancerous lesion are usually visible and always palpable, but these abdominal symptoms are vague. Patients suffering with them are impatient even of diagnostic measures. They desire immediate relief by diet or drugs. The control of cancer is therefore a problem of education. Those clinics which have the records, the pathologic proofs, must work up their statistics so that we may increase our evidence in proof of the statement that cancer has been cured. Every cured patient is additional evidence.

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These clinics can also furnish evidence of the increased probability of a cure in the early stages of cancer and the absolute certainty of a cure in the precancerous stage.

When patients seek advice in these earlier stages, the best results also depend on good surgery. We must establish in this country, on the available evidence, greater uniformity in the treatment of cancer in the different localizations.

No surgeon to-day should operate on a lump in the breast unless he is prepared for the complete operation for cancer if the tumor should prove malignant after exploration. The object of exploring every lump of the breast immediately is not so much to remove a possible benign tumor as to remove cancer in its most curable stage. No surgeon should remove a lump in the breast for microscopic study, delay a few days or weeks and then perform the complete operation for cancer if the tissues studied microscopically should prove to be malignant, because the patient whose chances to be cured were at least 80 per cent. will by such a procedure be almost doomed to death from cancer. The diagnosis must be made at the exploration of the tumor, and, in cases of doubt, the complete operation for cancer must be done.

No surgeon to-day should remove the breast alone for cancer. A few cures have been accomplished, but not enough to justify the procedure, even in exceptional cases. The mutilation of the most radical operation for cancer of the breast with skin-grafting, if properly performed, is nothing as compared with the possibility of a recurrence when a restricted operation has been performed.

Patients with malignant disease—carcinoma and sarcoma—present themselves for surgical aid in the following groups:

A. Hopeless, inoperable. There is no hope even for the palliation of the symptoms by any operation.

B. Inoperable, hopeless. Attempts to relieve pain and prolong life by some operative procedure.

C. Clinically malignant. Apparently operable, but at the operation the disease is found to have extended beyond possible removal with the knife or cautery.

These three groups—A, B and C—really represent inoperable cancer, and up to the present time have been incurable. I shall not discuss here the rare cases of spontaneous cures, the now and then apparently accomplished cures with radium and the Roentgen rays and the apparent cures of inoperable sarcoma with the toxins of prodigiosus and streptococcus.

For these miserable patients everything should be done; every method of treatment should be attempted. No surgeon or physician should allow skepticism to stay his hand or dampen his enthusiasm in attempting to help them. Admitting that there have been some few cures, admitting that there may be more, the percentage will be so small that no one with the knowledge of the true facts would delay to take his gambler's chances with treatment in this late and practically hopeless stage.

We do not often hear these hopeless groups mentioned except in statistical articles and larger monographs. Few physicians and surgeons and fewer of the people realize that in cancer in every possible localization the number of patients in these hopeless groups varies from 25 to 50 per cent.

In external cancer this hopeless condition is due to delay on the part of the patient from ignorance or fear. It is often due to procrastination (probably based on ignorance) of physicians consulted in the early stage. The hopelessness of delay in this group has often been increased by improper intervention, often early and in the most favorable time. The intervention is of various types—incomplete excision by those not trained in surgery; the cutting out of pieces for diagnosis; application of caustics of every type by those of our own guild (I trust, only by these ignorant of the danger) or by quacks, and with Roentgen rays and radium by enthusiasts.

It is to be remembered and emphasized that the treatment received by these patients is, as a rule, instituted in an early period, when experience shows that the best assurance of a cure is the radical cutting out of the disease with a knife in conjunction with, in some cases, the electric cautery. It should not be difficult almost to eliminate these hopeless groups of external cancer.

The clinical symptoms of a cancer of the uterus are so distinct that it should not be difficult to educate the patients and the profession, but unfortunately, even at present, the percentage of patients with cancer of the uterus seeking expert surgical advice in the inoperable group is still large. Thus far our educational efforts have not produced satisfactory results. We trust that later figures will be more encouraging.

In cancer of the stomach, gall-bladder, pancreas, colon, etc., in what we might call internal cancer, the educational problem is a much more difficult one. The beginnings of these malignant diseases are often insidious and slow, and the symptoms are not sufficiently distressing for the patient to be willing to undergo an operation for their relief.

We have trained ourselves to remove the appendix when the patient is suffering no discomfort at all and often when the attacks have been insignificant. We do not always remove the appendix, therefore, to relieve the patient of suffering, but often only to protect him from death from peritonitis. The inoperable groups of internal cancer will remain large until we have educated ourselves and others to understand that the object of exploratory laparotomy in a large number of cases is not so much the relief of symptoms as the protection of the patient from death from cancer.

William Mayo has recently shown that the largest number of patients with cancer of the stomach tell their physicians of symptoms from which they have suffered for from one to three years and longer, and which may be described as ulcer symptoms. Now, as a matter of fact, most people prefer ulcer symptoms to surgery of the stomach. Unfortunately, there is a difference of opinion as to ulcer symptoms and what they mean.

Surgeons whose aid is sought as a last resort feel from the evidence open to them that ulcer symptoms should be looked on as a distinct warning. The object of surgical intervention, then, is just as much for the protection from death from cancer as for the relief of the symptoms. In the early stage of ulcer symptoms the chances of curing cancer are the best.

We have the same available evidence for all forms of internal cancer, but at present there is no uniformity of views among the profession in regard to earlier intervention. The American Society for the Control of Cancer can be most helpful if it is able to collect the evidence which will absolutely prove to, and completely persuade, the large majority of the profession that laparotomy for minimum symptoms, or ulcer symptoms, has for its chief object the cure of cancer. This cure is accomplished either by removing the benign lesion which later might become cancer, or the early cancer already histologically present.

The patients with operable malignant disease may be divided into the following groups:

D. Clinically malignant. In this group, wherever the cancer may be situated, clinical symptoms have developed which, experience shows, with few exceptions indicate malignancy as definitely as the microscope.

E. Clinically benign. In this group the lesions, whether external or internal, exhibit none of the symptoms associated with malignancy. The nature of the disease is revealed either at the operation or later, after microscopic study.

In external cancer the diagnosis of malignancy may be made at the exploratory incision with or without the aid of a frozen section. In internal cancer we often make the diagnosis by palpation of the lesion after laparotomy.

The point that I wish to emphasize is this: So far as the operation goes, the surgeon can distinguish little difference between many of the clinically malignant and clinically benign cases. The axillary dissection in the breast lesion is just as favorable, the resection of the stomach just as simple. If these groups are carefully and properly selected, however, the difference becomes manifest after five years in the results—in the breast 80 per cent. of cures instead of 25 per cent. It seems to me that this evidence should influence every one to prefer the chances of an operation in that clinical stage in which the symptoms are either doubtful or entirely free from any evidence of malignancy rather than take chances in delay. Another factor is to be borne in mind: An operation at this stage, properly performed, should do no harm, and, even though it reveals no malignancy in its earlier stages, it may remove a focus in which the probability of development of cancer is great. This leads to the next operable group:

F. The precancerous lesion. Undoubtedly the hope for the almost complete eradication of cancer rests on the recognition and complete eradication of the precancerous lesion, whatever this may be.

In conclusion, the evidence which allows these deductions is based on the entire surgical experience of many surgical clinics, the results of which are carefully checked by pathologic examinations, and the ultimate results of which five and more years after operation are known.

The control of cancer, therefore, appears to be a matter of education and the chief object of the American Society for the Control of Cancer is to hurry on this education, so that more lives may be saved to-day.

I cannot refrain from adding the following argument in favor of surgical treatment in the precancerous or in the very early malignant stage, when the lesion is still relatively benign. Cancer in this stage is an "economical disease," at least, relatively. The expense of treatment is little, either to the hospital or to the patient, and the period of disability is short.

For most cases of external precancerous lesions, or the early stage of cancer still clinically benign, the lesion can be cut out under local anesthesia. The ordinary charge of the hospital for material at such an operation is from five to ten dollars. Most of these patients need not remain in the hospital, and often they will lose but a day or two from business. The period of disability after the complete breast operation varies from three to four weeks. The period of disability after a pylorectomy, a resection of the colon or a hysterectomy should not be more than three or four weeks. Operation in this early stage has practically no mortality, the postoperative discomforts and complications are least and the period of disability short. Delay simply means more expense to the hospital and to the patient, more danger, greater discomforts and decreasing probability of a cure.

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THE MUNICIPAL REGULATION OF MILK-SUPPLY *

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This paper is not concerned with the advisability of regulating the production, transportation, handling, and distribution of milk. I take it for granted that there is general agreement that the milk-supply should be subject to official supervision and regulation, just as any other matter affecting the health interests of a considerable number of citizens.

On the other hand, the character of the milk ordinances and rules in force in this country at present, the relation of state to municipal control, and especially the particular methods that experience seems to indicate as most effective are questions that it may be profitable to consider.

A few facts may first be presented bearing on conditions in the United States to-day. The data were obtained from answers to a set of questions sent out from the office of the American Medical Association to the health officers of all municipalities with over 25,000 population. The questions were not intended to cover all possible or desirable phases of milk regulation, but to elicit information on certain points thought to be significant of the scope and nature of present municipal control.

There were 229 cities in the United States in 1910 with a population of over 25,000. One hundred seventy-three of these replied to the questions. For convenience the cities were divided into five groups.

Group 1.—Population over 800,000; eight cities; no reply from Pittsburgh, Pa.

Group 2.—Population 100,000 to 500,000; forty-two cities; no reply from Jersey City, N. J., Oakland, Cal., or Worcester, Mass.

Group 3.—Population 75,000 to 100,000; twenty-two cities; no reply from Houston, Tex., or Reading, Pa.

Group 4.—Population 50,000 to 75,000; thirty-six cities; no reply from Akron, O., Charleston, S. C., Peoria, Ill., South Bend, Ind., or Waterbury, Conn.

Group 5.—Population 25,000 to 50,000; 121 cities; no reply from Amsterdam, N. Y., Auburn, N. Y., Bay City, Mich., Bloomington, Ill., Chester, Pa., Dubuque, Ia., East Orange, N. J., Green Bay, Wis., Kingstown, N. Y., Lewiston, Me., Lincoln, Neb., Malden, Mass., Manchester, N. H., Newark, O., New Rochelle, N. Y., Quincy, Ill., Quincy, Mass., Chicopee, Mass., Shenandoah, Pa., Shreveport, La., South Omaha, Neb., Springfield, O., Waco, Tex., Warwick, R. I., Woonsocket, R. I.[1]

Some of the answers to the questions are presented in tabular form (Tables 1 and 2).

It is seen that the requirement of a permit or license is practically universal in all cities of over 50,000 inhabitants. Some cities in the 25,000 to 50,000 group, however, require no permit and a considerable number have no ordinance regulating the sale of milk in any way.

A license requirement seems to be the first step toward proper control. It may be recalled that when the New York City Board of Health adopted an ordinance requiring all persons dealing in milk to secure a permit, the right was contested and carried to the Supreme Court

* Read at the Conference of the American Medical Association on Medical Education and Legislation, Chicago, Feb. 25, 1913.

1. There is reason to believe that the majority of cities in this group from which no reply was received have practically no regulation of the milk-supply.

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of the United States. That tribunal sustained the ordinance as a reasonable exercise of police power.

Dairy-farm inspection of some sort is carried on by the great majority of cities. This unquestionably varies in efficiency. The frequency of inspection ranges from "once in a year or two" and "when necessary" to regular monthly examinations. In general it seems to be true that dairy-farm inspection is more regularly and more effectively carried out by cities with a population of over 100,000 than by smaller municipalities. This is perhaps in part due to the larger sums of money available for health purposes in the larger cities, but it must be remembered that the farms supplying towns of 25,000 to 50,000 are relatively few in number and near at hand, so that the absolute expense of efficient inspection would not be great.

The score-card of the United States Department of Agriculture is commonly but by no means universally used. The dairy score-card, while undoubtedly of service, does not in the opinion of many health officers give a sufficiently satisfactory basis for judging the character of the milk reaching the consumer. General methods of cities with over 100,000 population have half or more of their supply pasteurized. A very striking feature of the reports is the general absence of any regulation dealing with the pasteurizing process, even in municipalities where a large proportion of the supply consists of heated milk. A number of health officers state that this condition will be remedied soon by the passage of ordinances dealing with the legal definition and control of pasteurization. A smaller proportion of the cities in the 25,000 to 50,000 group report pasteurization of any considerable part of the supply, but in them also, the pasteurizing process is evidently gaining ground. It is unfortunately true that supervisory control of pasteurizing plants is no more general in the small than in the large cities.

A comparison of the milk supply conditions in 1912 (Table 2) with those prevailing ten years previously is facilitated by a study made in 1902 by Alvord and Pearson[3] of the U. S. Department of Agriculture. Briefly stated, some of the principal changes in ten years appear to be:

1. An increase in the retail price of milk has occurred in all parts of the United States and averages 2 to 3

TABLE 1.—REGULATION OF MILK-SUPPLY IN CITIES*

Group	Population	No. Cities	No. Answers Received	Licenses Required		Av. Price Milk per Qt.		Dairy Farms Inspected		Cattle Tuberculin Tested	Bottling & Distrib. Plants Inspected		Bacterial Standard In Force		Bacterial Standard Range		Regulations Satisfactory	
				+	—	Sum.	Wint.	+	—	+	—	+	+	—	Max.	Min.	Yes	No
1.	500,000+	8	7	7	0	8	9	7	0	0	6[1]	7	0				3	3[1]
2.	100,000-500,000	42	39	38	1	8	9	37	2	14	25	28	0[1]	26	13	5,000,000	100,000	29	16[3]
3.	75,000-100,000	22	20	19	1	8.2	8.7	20	0	7	11[1]	20	0	14	5[1]	1,000,000	20,000	12	6[2]
4.	50,000-75,000	36	31	24	3[4]	8.4	8.6	29	1[1]	11	18[2]	30	0[1]	15	12[4]	1,000,000	100,000	12	14[5]
5.	25,000-50,000	121	96	76	16[4]	8	8.6	74	17[5]	28	65[3]	79	10[7]	38	52[6]	1,000,000	20,000	45	41[10]

* Numbers in brackets indicate number of cities not answering question.

TABLE 2.—PASTEURIZATION*

Group	Population	No. Cities	No. Answers Received	Over 50 Per Cent. Pasteurized	10 to 50 Per Cent.	0 to 10 Per Cent.	None	Inspection		Regulations		Bacterial Standard In Force		Bacterial Standard Range	
								+	—	+	—	+	—	Max.	Min.
1.	500,000	8	7	5	2	0	0	7	0	1	5[1]	4	3	500,000	50,000
2.	100,000-500,000	42	30	10	13	7	3[6]	33	2[4]	7	17[15]	14	21[4]	500,000	10,000
3.	75,000-100,000	22	20	3	10	0	1[6]	13	3[4]	4	10[6]	6	10[4]	500,000	10,000
4.	50,000- 75,000	36	31	4	9	6	6[6]	17	1[13]	4	12[15]	2	5[1]	50,000	50,000
5.	25,000- 50,000	121	96	9	21	14	33[14]	40	11[9]	10	33[21]	17	47[13]	500,000	10,000

* Numbers in brackets indicate the number of cities not answering question.

grading the supply on the basis of all available information, like those in use in New York City and Washington, D. C.,[2] seem to be growing in favor in the larger cities.

A number of municipalities require that the tuberculin test be applied to herds furnishing milk, but the requirement is far from universal (33 per cent.). Bacterial standards for raw milk, ranging from 100,000 to 5,000,000 (this is the only one over 1,000,000!) have been established by the large majority of cities with over 100,000 population (forty-six cities in Groups 1 and 2). Sixteen cities out of forty-six reporting fix a limit of 500,000. The cities with 25,000 to 50,000 population are much more generally without bacterial standard, largely, doubtless, because of the lack of suitable laboratory facilities for enforcing such a requirement.

The process of pasteurization is much more extensively employed in some cities than in others. In some of the larger cities, as much as 70 to 80 per cent. of the whole supply is pasteurized. About 30 per cent. of the cents a quart (in some localities certainly the greater part of the increase has gone directly to the producer).

2. An extensive development in methods of supervision and an increase in the amount expended for supervision have taken place. The city of Denver spent $1,200 for all supervision in 1902, $5,000 for farm inspection in 1912. Ten years ago the city of St. Louis spent $1,850 for the supervision of its milk-supply, in 1912, $5,650 was spent for farm inspection alone. Chicago expended about $10,000 for the whole supervision of its milk-supply in 1902 and about $25,000 on farm inspection alone in 1912. New York made 41,292 farm inspections in 1912 at a cost of $76,080. The same change has occurred in some cities of 25,000 to 50,000 population. Haverhill, Mass. (population 44,000), which expended $150 for supervision of the milk-supply in 1902 had increased the amount to $1,600-$1,700 in 1912. Little Rock, Ark., which reported no milk ordinance and no supervision over its milk-supply in 1902 was spending $3,750 for farm inspection in 1912. Together with this increase in

2. Woodward, William C.: A New Method of Grading Milk and Cream, Public Health Rep., Feb. 21, 1913.

3. Alvord and Pearson: The Milk-Supply of Two Hundred Cities and Towns, Bureau of Animal Industry, Bull. No. 76.

the amount expended for supervision has gone a change in the character of the supervision, which can on the whole be regarded as advantageous from the public health standpoint. It can no longer be said, as it was said in 1902, that "most of the inspection work consists in testing samples of milk to ascertain if they contain as much fat and other solids as required by the standard." There is no doubt that at present much more attention is paid to matters of real sanitary significance, such as the health of the cows, the conditions under which milk is collected and transported, and the health of persons handling the milk, than was the case ten years ago. It is encouraging to note also that the practice of adulteration and the addition of preservatives do not seem at present to be as widespread as formerly.

While there can be no doubt that the development in dairy inspection which has occurred in the last ten years has been on the whole in the right direction, it seems particularly important not to invite criticism from the sensitive agricultural interests by placing this branch of milk control in unskilled hands. When it is possible to make a statement like the following, the need of carefully appraising the competency of would-be milk inspectors is apparent.

"In the case . . . mentioned all but nine out of 343 dairies were condemned by the 'inspectors.' The inspectors were aged 26 and 21, respectively. The elder had never lived or worked on a farm, or in a dairy; his education to qualify him to make about half of the above noted inspections was gained in attending a dairy school from ten to fifteen days. Armed with the knowledge thus acquired, he in one day 'instructed' his associate, who had never lived on a farm or worked in or seen a dairy. With this one day's instruction our 21-year-old inspector condemned the other half of the above-mentioned dairies. This is taken from the sworn testimony of the 'inspectors' acting for a city having a population of over 200,000."[4]

Such extreme instances as the cases above cited are probably not common, but there is reason to believe that the cause of much opposition to reasonable milk standards and regulations may be traced to the vexation produced in farmers and dairymen by the acts and utterances of ignorant or overbearing inspectors.

It is questioned by some whether the large sums of money expended in dairy-farm inspection and score-card rating have really given an adequate return in the prevention of communicable diseases. It is pointed out that the real danger to the public health lies not so much in the entrance of cow manure into milk, objectionable as this is, as in the actual infection of the milk with disease germs. However this may be, there is no doubt that farm inspection with all its shortcomings has done much in the last decade to raise the standards of rural sanitation as well as to improve the general character of city milk supplies. Whether or not as a public health measure it deserves all the emphasis we are now placing on it is a matter for future experience to determine.

3. A particularly noteworthy change that has occurred in the past ten years has been the growth of the process of pasteurization. In New York City it could be said ten years ago that "perhaps 5 per cent. of the total milk-supply is pasteurized," while it was true in 1912 that 40 per cent. of the supply was pasteurized. In Boston the report in 1902 was that "very little pasteurized milk is on the market and it is not increasing in favor," but 75 per cent. of the market milk was pasteurized in 1912. The same change may be remarked in smaller cities. Instances picked at random are: Springfield, Mass., with "no milk pasteurized" in 1902, but with 20 per cent. pasteurized in 1912; Lansing, Mich., with "a very small amount" in 1902 and one-third in 1912; Aurora, Ill., with 10 per cent. in 1902 and 85 per cent. in 1912. Whether or not one believes this to be a change for the better, the actual conditions should be recognized and ampler provision made for supervising the process of pasteurization. At present many municipalities possess no regulations governing this important matter.

Without entering at this time into a further analysis of the answers to the questionnaire it is worth noting that of 172 health officers from whom replies have been received 80, or nearly one-half, regard their present local regulations for the control of milk-supply as unsatisfactory. The improvements suggested include such matters as better facilities for maintaining a bacterial standard, more ample provisions for the enforcement of existing regulations, strict application of the tuberculin test, while in a good many instances—towns of from 25,000 to 50,000—the desideratum is a proper milk ordinance. Some health officers suggest compulsory pasteurization either of all milk or of all milk not obtained from tuberculin-tested herds. The admirable New York City rules and regulations relating to the sale of milk are specifically mentioned in some cases as the goal to be reached.

On the technical-legal side two points may be touched on: (1) the need for a uniform or uniformly efficient milk ordinance which shall cover the essential requirements clearly and concisely and shall be open neither to the charge of legal vagueness nor technical inadequacy, and (2) the proper adjustment of state and local control. As an illustration of the present muddled situation respecting the first of these points I have collated some thirty-nine excerpts from milk ordinances dealing with the single question of milk delivery at houses where there is any contagious disease. The number of words in which this topic is dealt with in the various regulations ranges from 27 to 197. Many of the regulations examined prohibit the leaving of bottles or other milk containers, but allow milk to be poured by the milkmen into receptacles furnished by the families. When delivery of receptacles is allowed, the board of health is often, but by no means always, made responsible for overseeing their disinfection, before again passing them into circulation. One municipality declares that bottles must be sterilized by boiling "in water kept at the boiling-point for fifteen minutes, said sterilization to be done by the party using the milk." The milk dealer is made responsible for seeing that these directions are carried out and is to be penalized for receiving "such bottles not so treated" by having his license suspended or revoked! One of these sections recites that "no person, persons, firm, corporation or association shall refill any receptacle without being first washed," etc. Another guards against legal misunderstanding by the following language:

> It shall be unlawful for any person to serve any milk, cream, buttermilk, skimmed milk, pasteurized milk, condensed or evaporated milk, or condensed or evaporated skimmed milk, in bottles to any dwelling in which any person is ill with any contagious, infectious, or communicable disease, or to any dwelling on which there is a placard or notice stating or indicating that any person therein is ill with any contagious, infectious, or communicable disease until after such placard shall have been removed by the proper officer.
>
> It shall be unlawful for any person to remove from any such dwelling any bottle or receptacle which shall have been

4. Carlin: Creamery and Milk Plant Monthly, 1912, i, 10.

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or is to be used for the purpose of receiving, storing, or delivering milk, cream, buttermilk, skimmed milk, pasteurized milk, condensed or evaporated milk, or condensed or evaporated skimmed milk, or into which any milk, cream, buttermilk, skimmed milk, condensed or evaporated milk, or condensed or evaporated skimmed milk shall have been or is to be placed, or which is commonly used for the reception, storage, or delivery of milk, cream, buttermilk, skimmed milk, pasteurized milk, condensed or evaporated milk, or condensed or evaporated skimmed milk.

The confusion and divergence shown in both wording and intent are sufficient to demonstrate the desirability of drafting a model milk ordinance, which shall allow modifications for local conditions, and shall fit especially the needs of communities with from 25,000 to 75,000 inhabitants. Larger cities are at present fairly well off in the matter of milk regulation, but many of the smaller cities are without any ordinance at all and the health officers, as shown by their answers to the questionnaire, would welcome the opportunity to press for an ordinance backed by the prestige of some influential body of workers. Some of the discrepancy in practice and the confusion of legal phraseology which exist now in the milk rules of a few of the large cities might be cleared up also by an open discussion of the essential points to be included in a model ordinance.

The relation of local to state and federal control of health matters opens a wide question which can only be touched on here. Possible conflict between municipality and state in health matters is illustrated in the extraordinary act passed by the Illinois legislature on the tuberculin test.

It shall be unlawful for any city, village, incorporated town, county, or other incorporated authority by ordinance or otherwise to require the tuberculin test to be applied to dairy animals as a means of regulating and purifying milk, skimmed milk, cream, and other dairy products. Every such ordinance or regulation passed by any corporate authority other than the state of Illinois is declared void. (Filed, June 12, 1911, became a law without the governor's signature.)

This is an interesting reversal of the theory that the local authorities are likely to be derelict in health matters and that the state must step in and set things right. There is at present no legitimate appeal from such action on the part of the state. In practically all states of the Union the source of authority both for the creation of administrative bodies in health matters, and for the exercise of their power, resides in the state legislature.

Not only may a good regulation be superseded or annulled by a state enactment, but duplication and confusion may be brought about by the existence of conflicting state and municipal regulations. This is particularly so in a matter like milk-supply, where the protection of public health may require interference with an economically important and politically influential interest. City dwellers may be at the mercy of the embattled farmers to a practically limitless extent. Fortunately a spirit of fair play often prevails and the predominantly agricultural counties rarely attempt to club the cities into submission. This is all the more reason for recognizing the present unsatisfactory situation.[5]

In many states there are two sets of inspectors, state and metropolitan, visiting the same farms and attempting to regulate the same industry. Even when regulations do not actually clash state and city are apt to have somewhat different standards, and state and city inspectors will approach the dairy-farms from quite different points of view, as is inevitable considering the derivation of their authority. In England a somewhat similar conflict has been recognized between the health needs of a town community and the agricultural interests of the surrounding district. The *British Medical Journal* (Dec. 21, 1912) thus comments on the Milk Bill recently under discussion:

On December 10, the president of the local government board introduced a bill to make better provision with respect to the sale of milk and the regulation of dairies in England and Wales. . . . In order to secure improvement in these particulars, the Milk Bill provides for the inspection of dairies by the medical officer of health—a duty which is already imposed on that official. We have no hesitation, however, in saying that the results of those inspections, and of the reports and recommendations which will be the outcome of them, will continue to be unsatisfactory, and for this reason: The medical officer of health is elected by, and may be dismissed at three months' notice by, the rural district council, the members of which in many instances are either themselves dairy farmers or their friends and neighbors. . . . For years past royal commissions and committees have recommended that medical officers of health should not be removable from office except with the sanction of a central authority, and we have reason to know that the urgency of this reform has been impressed on the Rural Housing Inquiry Committee, which is reporting to the Chancellor of the Exchequer, so that the government is not ignorant of this necessity and importance. Opportunity was taken on the passing of the Housing, Town-Planning, etc., Act, 1909, to give security of tenure to medical officers of health of county councils, who are far less likely to come into direct conflict with the holders of insanitary property, etc. If the government has a real desire to improve the milk-supply of the country, it will place medical officers of health of districts in a like unassailable position so long as they carry out their duties in a satisfactory manner.

The apparent conflict between the agricultural interests and the requirements of public health is not the only difficulty met by health authorities. In some instances the actual power of the local board of health has been called in question. In Massachusetts the supreme court recently decided adversely to the regulation of the Boston Board of Health restricting the sale of so-called "loose milk." The supreme court was of the opinion "that the statute under which the board assumed to act is not broad enough to give them this authority." The very same decision, however, goes on to declare that "we do not consider the question whether this regulation goes beyond the constitutional power of the legislature to enact as a statute or to authorize the board of health to establish locally."[6]

Both as regards the real power of local boards of health and as regards the overriding of local authority by state legislatures there seems ample opportunity for discussion. The present tendency seems to be for the state to assume authority over many matters previously left to local control. State commissions and state boards are appointed to exercise supervision over minute details of municipal administration. It may be questioned if on the sanitary side this may not be carried too far. The problems of sanitary administration in a large city are of quite a different nature from those in small towns or in thinly populated districts, and it is certain that gen-

5. At an interstate conference in New York City in February, 1913, delegates from eight states on the North Atlantic seaboard discussed the state control of the milk industry. Three delegates from each state representing, respectively, the State Board of Health, the State Agricultural Department and the dairy interests of the state, were appointed by each governor. The results of the conference are thus interpreted by a trade journal (Creamery and Milk Plant Monthly, February, 1913): "The theorists and the medical extremists on the governing of milk-supply were voted down . . . and the practical and common-sense view prevailed." The consequences of having an industry regulated by its "friends" are familiar to the American people.

6. Am. Jour. Pub. Health, 1912, ii, 107.

eral state regulations applying to the latter group will often not fit the needs of the former. Local regulation in sanitary matters which are largely dependent on local conditions would seem a reasonable exercise of the principle of self-government. The fundamental principle of home rule is violated by any state enactment which, like the Illinois law before cited, forbids the inhabitants of any city to take measures that they consider desirable for the public health. We need not have too much fear of being checked on the legal side in an attempt to adjust local and state jurisdiction. The courts will in the long run reflect dominant public opinion. In this very matter of milk regulation where conflict of authority and wasteful duplication at present exist the legislature and the courts must be made acquainted with prevailing scientific opinion, and there will be little doubt of the final outcome. In the recent decision on the cleaning of milk receptacles rendered by the Court of Special Sessions of the City of New York the recognition of the peculiar health needs of a great metropolis is everywhere apparent.

> It does not seem that the clause that provides that anyone who has in his possession such unclean receptacles is guilty of a misdemeanor in any way conflicts with the aforesaid law, but that it is an enactment in addition to the Agricultural Law, which the board of health is empowered to make for the greater welfare of the inhabitants of a great metropolitan center. When one considers the physical conditions which surround a cosmopolis like New York City, the crowding together in small places of so many individuals; the dirt, filth and germs which are bound to accumulate in spite of most strenuous efforts; the poverty, sickness and uncleanliness of so many citizens, it is at once apparent that the greatest care must be taken in the transportation of a commodity like milk, which is daily used practically in every family, and which is without doubt more susceptible of taking up germs and scattering them broadcast than any other product. . . . The Sanitary Code in Section 183 has as its object the prevention of the creation and spreading of disease germs and pestilence in a crowded city, and the act of the defendant in carting these unwashed cans to a railroad station to be shipped in that condition is a dangerous act, and any statute forbidding such a practice is unquestionably reasonable in character.[7]

The Appellate Division of the Supreme Court of New York later affirmed this judgment with the significant remark:

> Both the statute and the ordinance are undoubtedly drastic, but the danger to be apprehended from the use of unclean receptacles for milk intended for human food is too obvious and so well known that drastic measures to prevent the possibility of such use are reasonable and justifiable.[8]

It is sometimes asserted that the authority of a city inspector ends at the city line and that outside dairy inspection or interference with milk shipments from a distance is unjustifiable. Under this head another recent decision handed down by the Court of Appeals in New York is of great importance. A dairyman outside the city of New York sued the chief of division of food inspection for damages sustained through his official action in notifying a creamery company not to include the plaintiff's milk in its shipments to the city, the officer in question having acted on the report to his department by its inspector that the conditions of the plaintiff's dairy were insanitary. The complaint was dismissed in the Supreme Court of Delaware County, and was appealed by the plaintiff with the result that the judgment is affirmed. The decision includes the following lucid and emphatic statement:

> The Department of Health of the City of New York is charged by law with the responsibility of preventing pestilence and disease in the city of New York. Its duty is to enforce all laws applicable to the preservation of human life and the promotion of health and such as relate to the use or sale of unwholesome, deleterious or adulterated food. In the faithful and efficient performance of that duty, the whole state, as well as the city, is concerned, and the department must be deemed to possess whatever power is needed to make effective the express powers conferred. . . . Of the food-supplies introduced into the city of New York, milk is one of the most important. It is now a matter of common knowledge that, if infected, it carries with it the germs or bacilli of dangerous and epidemic diseases. It is the food of the infant and it is an important element of the food of the adult. It may be infected as it comes from the cow or it may be contaminated by reason of the insanitary conditions of the dairy. Whatever, therefore, the department of health may do toward preventing the introduction of milk into the city of New York, which its officers have reason to believe is unwholesome and deleterious, is in the performance of a statutory duty. It is unreasonable to say that the department of health, in exercising such a power, renders itself amenable to the charge of exercising an extraterritorial jurisdiction. In notifying the creamery company not to include the plaintiff's milk in its shipments to the city, it was acting for the protection of the inhabitants of the city of New York, and, therefore, for local interests. There was no interference with the plaintiff's conduct of his farm or business except as he proposed to supply milk to the city of New York there was simply an embargo laid on the introduction within the city of New York of any milk not produced by him under conditions specified by the department. It had the right to exact from all shippers of milk a compliance with such conditions as would reasonably tend to a pure product for the use of the citizens, as a condition of permitting its sale in the city of New York. In exercising the supervision and in taking the preventive measures, which appear in the evidence, the department of health was properly and reasonably executing the duty imposed on it by the statute of conserving the public health; in which, as I have already observed, the state at large is equally interested with the city.[9]

The right of a municipal health department to confiscate and destroy milk not conforming to standard has been sometimes questioned, and the Wisconsin Supreme Court decision (May 12, 1913) marks the first legal test of the matter.[10] The tenor of the decision is similar to those already cited:

> The ordinance is not an arbitrary and unreasonable deprivation of property in a wholesome food, but a regulation having the purpose of and found to be necessary for the protection of the public health. The police power of the state must be declared adequate to such a desired purpose. . . . Even if the necessity of the tests be not demonstrated and the beliefs which induced them may be disputed, they cannot be pronounced illegal. . . . We agree with the court that the destruction of the milk was the only available and efficient penalty for the violation of the ordinance.

There is thus ample evidence that the courts stand ready to uphold the enforcement of ordinances and measures designed to protect the public health, and that they will support any reasonable regulation of the public milk-supply. The opinion of disinterested experts and of officials who are endeavoring to serve the public health is bound to have greater weight with the courts than the pleadings of self-interest. While no one questions that the individual should be protected from injustice on the

7. Month. Bull. Dept. of Health, City of New York, December, 1912.
8. Month. Bull. Dept. Health, City of New York, February, 1913.
9. Weekly Bull. Dept. Health, City of New York, March 15, 1913.
10. Weekly Bull. Dept. Health, City of New York, June 14, 1913.

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part of the community at large, it is nevertheless true that the health interests of the community are likely to remain paramount, and that individual hardship or injury must be acute indeed if consideration for it is suffered to override the regulations deemed necessary to safeguard the public health.

Attention may be called finally to a means for stimulating a sense of responsibility in milk-dealers which has as yet been taken little or no advantage of in this country. In Great Britain, both juries and the Court of Appeal have answered affirmatively the question of the liability of milk-dealers for cases of infection traced to milk. In one instance, cited by Savage,[11] the Court of Appeal held that the sale of an article for a specific purpose carried an implied warranty by the vendor that it was reasonably fit for the purpose and that there was no exception as to latent undiscoverable defects. In another case, a question of liability was held to be unaffected by the assumption that the farmer had taken all possible precautions.

The municipal regulation of milk-supply in the United States at present seems to lack little in the way of legal authorization or of support by enlightened public opinion. Dairy inspection, bacterial control and proper grading seem to have been carried farther in this country than anywhere else. Perhaps the points in most immediate need of improvement are (1) the definition and proper control of the process of pasteurization, and (2) the adoption and enforcement of suitable milk-supply regulations in cities with less than 50,000 population.

SEVEN CASES OF EPILEPSY IN CHILDREN

TRACED TO SINGLE ALCOHOLIC INTOXICATIONS ON THE PART OF ONE OR BOTH PARENTS OTHERWISE TEETOTALERS *

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The relation of alcoholism to epilepsy is a subject of such magnitude, so comprehensive, varied and yet so familiar, that I shall confine myself briefly to but one small section or aspect of it—not so far as I know specifically referred to by previous writers—namely, the relation that single alcoholic inebriations on the part of one or both parents otherwise teetotalers bears to the child whose genesis occurs under such condition. It has been estimated that there are about 30 per cent. of epilepsies, not including other ancestral neuropathic disorders, in which a family predisposition cannot be found. It is an attempt to explore, even if inadequately, this pathologic *terra incognita* and point out as far as possible the origin of at least a few of these that this paper is written; for there must be some cause, connected probably with progenitors, to explain the elusive 30 per cent. whose primal chronology is at present shrouded in mystery.

In the light of comparatively recent physiologic discovery connected with the temporary effect of alcohol on the system at large, pointed out perhaps first by Richardson, and since notably by Schnyder and Dubois of Berne, Switzerland, Kraepelin of the University of Munich, Martin Mayer of Heidelberg, Hellsten of Helsingfors and Aschaffenberg of Munich, it seems possible to perceive that intoxication of one or both parents at the time of conception, independently of the physical and nervous deterioration common to chronic drunkards, may make clear the causation of some of these, as it seems to have explained to me the seven cases whose histories I am about to relate. According to the observation of nearly all epileptologists, there can be no doubt in regard to the effect of alcohol in general as a frequent factor in the production of epilepsy. The difference among observers is one of degree rather than kind. Maudsley, for example, is responsible for the startling expression that "epileptics, because of drink on the part of parents, are as much manufactured articles as are steam-engines and calico-printing machines."

In regard to the rôles played by even ancestral epilepsy as contrasted with ancestral drunkenness as causes of congenital epilepsy, opinions differ but slightly, but mostly agree on the main point, that drunkenness rather than epilepsy itself is more prolific in transmitting epilepsy to offspring. For America, Dr. Spratling of the Craig Colony for Epileptics at Sonyea, N. Y., is the dissenter in regard to this point. He says that only 14 per cent. of the thousand inmates of his institution had drunken parents, while 16 per cent. had epileptic parents; but Echeverria, the first American to write a book about epilepsy, in an analysis of 572 patients, gives parental intemperance as the cause of 17.5 per cent., while parental insanity associated with epilepsy stood for but 15 and a fraction per cent. This is a remarkable statement, as it shows in Echeverria's group of 572 cases that a greater percentage of epilepsies was produced by drunken parents than by epileptic and insane parents combined.

For France, Molli has assured us that of all persons inheriting impaired nervous systems from drunken parents, from 30 to 40 per cent. of them were epileptics, and the same writer quoting from M. Hippolyte Martin, who collected a great many curious facts about ancestral intemperance and its visitation on children to the third and fourth generation, says that in 150 cases of insane epileptics at the Salpêtrière, he found that eighty-three had intemperate parents, that is, nearly 60 per cent.; and of the 2,554 children admitted to the Bicêtre suffering from idiocy, epilepsy, imbecility and hysteria, 1,053 were the offspring of drunken parents. The same writer followed to the death a number of these patients to show that no hereditary tendency other than alcoholism produced the susceptibility to convulsions.

Dejerine also said of France that "51.5 per cent. of all epilepsies in children are due to parental alcoholism and but 21 per cent. to parental epilepsy." Thus, emphasizing again, I repeat the remarkable statement of Echeverria that as far as congenital epilepsy is concerned, it is more dangerous to the prospective child, other things being equal, to have a drunken than to have an epileptic father or mother.

For Germany, Binswanger declares of epileptics "made in Germany" that 22 per cent. of them have had their origin in chronic parental inebriation, while but 11 per cent. were due to parental epilepsy.

I should not refer to these familiar, if curious, statements with regard to the ravages of these rivals in destruction—epilepsy and drink—these twin brothers I might say in etiologic iniquity—were it not for their closeness, as it were, in consanguinity to what will be said later on.

In explaining the relationship of parental drunkenness as a causative factor in the production of the disease under discussion, it has been the custom with writers on

11. Savage: Milk and the Public Health, Macmillan & Co., London, 1912.

* Read in the Section of Psychiatry of the Seventeenth International Congress of Medicine, London, 1913.

the subject to refer it almost exclusively to that state of bodily and other deteriorations brought about by chronic alcoholic excess—such as "physical wreck," "disorganization and disturbance of the nervous system," "loss of muscular equilibrium and its cause," "diseased stomach, liver, intestines," "lowering of the bodily temperature, depression and acceleration of the heart resulting in degenerative lesions," "disintegration of muscular nerve and organic tissue," "toxemias," "degeneration of cerebrospinal system," "abnormal state of the upper portion of the cerebral mass, when the mind loses, if but periodically, its controlling influence and the rational faculties give way," "the effect on nerve structure, mucous and serous membranes," "the blood and all secretions," and any or all the physical woes released from their Pandora box by inebriety.

Children whose genesis results from the union of the victims of such physical discrepancies must almost necessarily, we may think, be born with that reflex susceptibility and the like which makes them prone to epilepsy or other mental and motor disturbances; or, in other words, it would seem that offspring born as the result of the consorting of such abnormal persons must inherit a physical or nervous vulnerability not like Achilles', of the heel only, but of the whole nervous system, which but waits for the inescapable touch of the invisible hand—the special exciting cause—to develop into epilepsy or other such diseases as vasomotor spasms, chorea and allied distempers and degeneracies of the nerve centers, and that whole school of juvenile invalidisms seen chiefly in sanatoriums for the feeble-minded, idiots, imbeciles and the insane. This, then—drunkenness—is usually and properly given as the explanation of many epilepsies, especially when the family landscape presents a background of protracted intemperance.

Yet, although according to the consensus of opinion as exhibited by the authorities I have quoted, drunkenness and its consequent degeneracy explain about 35 per cent. of epilepsies, it does not at all explain the cases I am about to enumerate, for the parents of these patients were not physically degenerate; there was no history of epilepsy or other neuroses in their respective families, and they were not addicted to intemperance, or in any way enfeebled by disease or excess, except one father, who was consumptive in the last stages of the disease, living in a camp with other consumptives, and visited but on rare occasions by his entirely normal wife.

Case 1.—The child, the result of this union, at a time when the father was under the influence of liquor, was posthumous, being born six months after the death of its father, who died suddenly while mailing a letter three months after the last visit of his wife. The child developed epilepsy in its third year.

Case 2.—The patient was the child of an engineer called from home to fill an important position on a sugar plantation in Cuba. He had been a total abstainer, but before embarking for his new quarters, leaving his wife and two children behind, was tendered a farewell banquet by friends, when he got into a state as he called it of "alcoholic hilarity," the first time in his life. Nine months after his embarkation for his new post his wife gave birth to a son who developed epilepsy in his fifth year.

Case 3.—The patient was the daughter of the widow of a soldier who died in the Philippine Islands of dysentery three months after landing. His wife assured me that she never knew her husband to drink anything intoxicating until a few days before his enlistment, when he came home in a state of alcoholic excitement, after having spent the day with some soldier friends. Next day he enlisted and she never saw him again. In due time a boy was born; on the third day after its birth it went into convulsions, remaining in them for nearly two days, and since—until it came under my care seven months ago—it averaged during the eight years of its life about one grand mal weekly, with frequent attacks of petit mal, although it has had as high as six convulsions in a day.

Case 4.—The patient was the daughter of a medical man who had never tasted liquor until the night of his first intoxication. When he began the study of medicine he was married, with two healthy children. There was no family history of epilepsy or other neuroses. On the night of the commencement of his college, one of the professors, as was the custom, gave a reception to the new-fledged doctors, when he drank his first glass of wine and another and another, and promptly became intoxicated. He declares that his epileptic child, born about the regular time after this "debauch," as he called it, developed convulsions in its second year, consisting at first of but three, at intervals of a week apart, when they disappeared for two years, but returned again at periods of about one every two or three months. Of late, they have been developing with greater rapidity, showing, too, an erratic disposition on the part of the patient amounting to mild insanity.

The other three illustrations coming under my observation are already on record.[1] Two of them, in different families were traced by the parents themselves to single transgressions in the use of intoxicants. The father of one of the families afterward became a chronic inebriate and died of pneumonia following an attack of delirium tremens, but outside of that there was no trace of degeneracy in his race as far as could be discovered. The child is still living, an inmate of an epileptic colony. The wife is married again and the mother of two robust children.

These, in all probability, would have been accounted among the 30 per cent. of epileptics the origin of whose conditions would have been unknown but for pointed questionings, for the most abstemious of people may on anniversary or other occasions lapse into an intoxication not desirable to remember, or perhaps never thought of in connection with the resultant sick child.

I know no better explanation, therefore, of the advent of at least some of these unsound members into otherwise healthy families, than the one that tells that they entered while at least one of the sentinels was drunk.

This theory, then, suggested by the chapter on alcohol in Richardson's "Diseases of Modern Life," Metchnikoff's "Studies of the Blood," and the recent investigations of the German writers mentioned in the beginning of this paper will enable the physician, I think, to trace the origin of many cases of epilepsy of unknown cause back to their probable source.

Richardson pointed out long ago the changes effected almost instantly on the constituents of the blood by alcohol, and Metchnikoff since, in perhaps a more intimate study, has shown in particular its effect in producing temporary paralysis of the white corpuscles—the phagocytes.

Since alcohol, therefore, produces such important changes in all the ingredients of the vital fluid, as well as the secretions, may we not, reasoning by analogy, assert that it also influences or changes the constituents of the seminal fluid, paralyzing temporarily and otherwise altering the spermatozoa as it does the corpuscles and serum so that we might hazard the conjecture that it is not so much chronic drunkenness, as drunkenness at the time of conception, that causes the transmittal of an often overwhelming neurosis to offspring, and that at least some of these anomalies of apparently spontaneous development may be prevented by avoidance of the use of alcohol at the time of prospective procreation?

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1. Woods, Matthew: Relation of Alcoholism to Epilepsy, The Journal A. M. A., Feb. 9, 1907, p. 469.

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RESULTS OF STAPHYLOCOCCUS SPRAY TREATMENT IN FORTY-TWO CASES OF DIPHTHERIA CARRIERS *

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Since diphtheria antitoxin has come into general use, quarantine of diphtheria cases is especially irksome. The patient is apparently perfectly well in a few days and the members of the quarantined family think that they are needlessly oppressed. The fact, remains, however, that although the use of antitoxin results in a speedy disappearance of all symptoms, nevertheless the diphtheria organisms may still be found in the throat, and are just as likely to infect others as they were when the patient was sick.

It is impossible to tell from the ordinary examination by culture whether the bacilli are virulent or not, and as animal inoculation is not usually possible in municipal laboratories, the quarantine is sometimes continued until the germs disappear from the throat, two or three negative cultures being required for release. This sometimes extends the period of quarantine for several weeks and it becomes a severe hardship to the family affected.

The period of time during which the throats remain positive varies with different patients and different epidemics. Nuttal and Smith[1] state that the average time during which notified cases remained positive was 31.6 days, infected healthy contacts averaging 36.4 days, ranging from seven to ninety days. In an epidemic of diphtheria in New Castle, Pa., in 1912-1913, there were 125 clinical cases and ninety healthy contacts were cultured; 80 per cent. of the clinical cases and 77 per cent. of the healthy contacts remained positive thirty days or longer. It is not known how much longer these throats remained positive, since no cultures were taken after sixty days.

It would seem, however, that the organisms had lost their virulence to a great extent since the children were permitted to attend school after sixty days even though they had positive throats. A close watch was kept of these children and it did not appear that they spread the disease.

It would certainly be very gratifying if some means could be devised whereby these throats could be freed from the diphtheria organisms, thus lessening the period of quarantine and the danger of infection.

Various antiseptic solutions have been used without much success; Loeffler stated at the Fifteenth International Congress on Hygiene and Demography that he had not found any treatment very helpful in clearing up the throats. Schlotz[2] observed that in cases in which he had found the throats infected with diphtheria bacillus, a supervening infection with staphylococci caused a disappearance of the diphtheria organisms. Thinking that possibly the staphylococcus smothered out the other organisms, he obtained a staphylococcus culture from a healthy throat and applied it to the throat of five diphtheria carriers. The diphtheria organisms disappeared promptly and he concluded that the staphylococcus caused the disappearance.

Other workers have experimented along this line: Catlin, Scott and Day[3] report its use in twenty-two cases with apparently good results, Alden[4] reports sixteen cases with good success. Others reporting investigation are Page,[5] Lake,[6] Bell,[7] Wiener,[8] and Slack, Arms, Wade and Blanchard.[9]

Lorenz and Ravenel[10] report the use of a spray consisting of a bouillon culture of *Staphylococcus aureus* or a fresh suspension in salt solution. Seventeen patients received the treatment. In three pure carriers the results were very good. In six clinical cases in which the throats remained positive after recovery, four cleared up in one week, while in two cases the results were not so good. In eight cases treated early in the disease, four cleared up promptly, while three remained positive for twenty-two, thirty-six and thirty-nine days. Fay,[11] in a study including both the staphylococcus spray and antiseptics, did not obtain very good results from the spray. De Witt[12] reports that there is no antagonism between the two organisms in test-tubes, and in animals the results are not encouraging.

Thinking that perhaps we might derive some benefit from the use of the staphylococcus spray in lessening the period of quarantine, we used it in New Castle during the winter of 1912-1913. The spray consisted of a bouillon culture of *Staphylococcus aureus* at least twelve hours old or a fresh suspension in salt solution. Only one strain was used. This organism was obtained from the throat of a child of a family in which five other children presented positive diphtheria throats, this one alone being negative and furnishing a pure culture of *Staphylococcus aureus*. One member of the family had diphtheria, the others all receiving prophylactic does of antitoxin.

The spray was prepared in the municipal laboratory and delivered personally to the attending physician or nurse with explicit directions as to its use. They were directed to spray copiously both nose and throat three times or more each day and cautioned not to use any other form of treatment. The families were all intelligent people and anxious to use the spray to the best advantage, so that it would seem that the results should be a fair test of the value of the treatment as applied to municipal work.

The physicians and families were told the nature of the spray and asked to give a full account of its use. No one reported any untoward results.

Two classes of patients were treated: those who had showed clinical symptoms and still harbored the bacilli, and those who had not presented any symptoms but were healthy carriers.

Of twenty-two cases of diphtheria treated with the spray, five cases, or 22.8 per cent., showed two negative

* Because of lack of space this article is abbreviated in THE JOURNAL by omission of the tables. The complete article appears in the author's reprints.

1. Nuttal, C. H. F., and Smith, G. S. Graham: The Bacteriology of Diphtheria, 1908, p. 421.

2. Schlotz, A.: Ugesk. f. Laeger, 1910, lxxi, No. 49, abstr., THE JOURNAL A. M. A., Jan. 29, 1910, p. 422.

3. Catlin, S. R.; Scott, L. O., and Day, D. W.: Successful Use of the Staphylococcus Spray on Diphtheria Carriers, THE JOURNAL A. M. A., Oct. 28, 1911, p. 1452.

4. Alden, A. M.: The Staphylococcus-Spray Treatment of Diphtheria Carriers, THE JOURNAL A. M. A., June 14, 1913, p. 1876.

5. Page, Henry: Diphtheria Bacillus-Carriers, Arch. Int. Med., January, 1911, p. 16.

6. Lake: Med. Rec., New York, 1912, lxxxi, No. 26.

7. Bell: Lancet Clinic, cviii, No. 9.

8. Wiener, R. G.: Use of Bouillon Culture of Staphylococcus Pyogenes Aureus in Diphtheria Convalescents and Bacillus-Carriers, New York State Jour. Med., 1913, xiii, 61; abstr., THE JOURNAL A. M. A., March 8, 1913, p. 783.

9. Slack, F. H.; Arms, B. L.; Wade, E. M., and Blanchard, W. S.: Diphtheria Bacillus-Carriers in the Public Schools, THE JOURNAL A. M. A., March 19, 1910, p. 951.

10. Lorenz, W. F., and Ravenel, M. P.: The Treatment of Bacillus-Carriers by Overriding with Staphylococcus Aureus, THE JOURNAL A. M. A., Aug. 20, 1912, p. 690.

11. Fay, J.: Staphylococcus Spray for Diphtheria Carriers, California State Jour. Med., 1913, xi, No. 5; abstr., THE JOURNAL A. M. A., June 14, 1913, p. 1920.

12. De Witt, Lydia M.: Preliminary Report of Experiments in the Vital Staining of Tubercles, Journal Inf. Dis., 1913, xii, 68, abstr., THE JOURNAL A. M. A., Feb. 8, 1913, p. 475.

cultures before thirty days, while of twenty-two cases not sprayed, four cases, or 18.2 per cent., cleared up before thirty days. This would seem to indicate that the spray was not of much help in clearing up the throats.

In twenty cases of healthy carriers treated with the spray, seven cases, or 35 per cent., showed two negative cultures before thirty days, while of twenty cases not sprayed, four cases, or 20 per cent., cleared up before sixty days—not a very encouraging showing.

Of forty-two throats treated with the spray, twelve cases, or 28.5 per cent., cleared up before thirty days.

Of forty-two throats treated without the spray, eight, or 19 per cent., cleared up before thirty days.

CONCLUSIONS

1. The use of the spray caused no unpleasant symptoms.

2. The use of the spray did not appreciably lessen the period of quarantine.

3. The preparation and distribution of the spray entails a large amount of work if there are many cases.

4. Apparently most of the carriers do not spread the disease after sixty days from the day the disease begins.

5. Public health officials could work more effectively if they had some practical method of determining the virulence of diphtheria bacilli found in the throats of carriers.

THE DESIRABILITY OF EARLY DIAGNOSIS OF MENTAL DEFECT IN CHILDREN, AND MENTAL TESTS AS AN AID*

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The physician may come in various ways in contact with mental deficiency of varying degrees, and his ability to diagnose a given case will often be taxed severely unless he keeps clearly in mind the essential nature of the condition and brings to his aid all available diagnostic means.

Every physician of experience recognizes the undirected and shifting gaze, the lack of prehensile grasp and the general failure of response to external stimuli through the special senses that indicate idiocy in the infant. He may also recognize the group of symptoms that indicate some form of primary dementia.

He is, however, aware that the great majority of children that show mental abnormality are neither idiotic nor affected with any psychosis and that their condition is not even included in the well-recognized types, usually associated with mental deficiency, such as cretinism, mongolianism, hydrocephalus, microcephalus, etc. He has little assistance from the common textbooks and he must be content to explain the condition in terms of such popular phrases as "a little queer," "rather backward," "not quite like other children," or something equally indefinite. It is not at all uncommon for a physician to tell the parents of a mental defective that the difficulty will pass away at puberty, or to recommend a course of special training with a view to restoring the child to a normal condition, overlooking entirely the essential feature of the defect.

To reduce the problem to its simplest form let us emphasize the following facts:

1. Mental deficiency is a condition resulting from physical deficiency or impairment in the brain and nervous system which becomes manifest during the developmental periods of infancy and childhood, and is neither curable nor outgrowable, and is not to be confused with forms of pedagogic retardation from remedial causes.

2. It is not, when uncomplicated, to be confused with insanity which represents an alienation from a normal condition usually after mental development has been completed.

3. It may be complicated with a psychosis or epilepsy or other disorder, functional or organic, but when this is the case, the mental retardation or degeneration naturally receives secondary consideration and is usually the result of the disease, or at least, they owe their origin to a common cause.

4. It follows from the foregoing that the diagnosis of mental defect is made by comparing the reactions of the patient to his surroundings with those of the average normal child. When a person experienced in handling mental defectives is called on to diagnose a case, he immediately seeks as complete a knowledge of the history of the activities of the child as may be necessary to make the comparison clear; the less the mental defect, the more complete the history required; the reactions in the home, on the playground and in the school form the basis for diagnosis rather than symptoms observed by casual direct examination.

Thus the problem, as ordinarily presented to the physician — and it is usually the family physician who first discovers it, or is first consulted concerning the child that is "not right" mentally—is a psychologic one. Whether or not any definite pathologic condition might previously have been discernible, it goes without saying that in the great majority of cases of this kind, as presented to the physician, no definite lesion can be discovered that accounts for the mental condition—and it is the mental condition that causes his advice to be sought—and so he is at a loss for any standard by which to make his own mental picture of the case clear, to say nothing of meeting the anxious inquiries of parents and friends with a satisfactory diagnosis and prognosis, unless there is a profound or near profound idiocy or a marked psychosis. It is here that the system of measuring intelligence comes into service, and the Binet-Simon tests afford the best means so far devised for this purpose. They are rapidly serving to standardize mental retardation and defect. They represent a system of about fifty-five procedures to which the reactions of the child give the examiner as much information concerning his intelligence as the longer and more indirect methods, which even the expert must otherwise employ. While the system is entirely empirical, it is the selected result of work with normal and abnormal children during a period of twenty years. To better appreciate their *raison d'être* and their application, one should note the following basic principles involved in the child's development.

1. Psychologists teach us that the evolution of the intellect, using the term in the sense of capacity for knowing, is completed in children at about 13 years of age or 15 years as a possible maximum. During the evolutionary period the child is growing in capacity month by month and year by year, more rapidly during infancy and at a lessening rate in later childhood until it ceases at the end of the period stated.

* Read in the Section on Diseases of Children of the American Medical Association, at the Sixty-Fourth Annual Session, held at Minneapolis, June, 1913.

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2. It is quite evident from this that if from any cause, whether it be an inherited deficiency in germ cell potency, or toxic or traumatic influence during fetal life, infancy or early childhood, this evolution be interfered with, the child's mental capacity is lessened. The mental evolution may cease at an early period—or rather, it may never get under way, as in idiocy; or there may be a simple slowing down so that the child's capacity at any age below 13 is less than that of a normal child at the corresponding age, and its capacity at 13 (or at least 15) never increases. As the system of measuring intelligence enables the qualified examiner to determine the mental age of the child, it is obvious that if its development be retarded, the amount of retardation will be expressed by the difference between the mental age and the chronologic age, if the child is under 13, or 13 less the mental age if over 13.

As to reliability of tests it is unnecessary here to say more than that while there is considerable difference of opinion in regard to the relative value and proper age adaptation of certain particular tests, these are minor details. Goddard and Kuhlmann, who have done more work with the tests in this country than any other psychologists, as well as others, like Huey, Wallen, Towne, Terman and Childs, who have done enough to speak with authority, agree as to their general reliability.

As to the qualifications of an examiner, when the tests were introduced into this country by Goddard, there was considerable apprehension in regard to their use by any but expert psychologists. The fact is now conceded that this is not justified. I was at first inclined to share this view, but after observing the working of the system as applied methodically and thoroughly to over 1,500 mental defectives and on over 1,000 schoolchildren (by Kuhlmann and under his direction), and after observing the work of different teachers under training in the use of the system, I have become convinced that this is unnecessary. What is more to the point, however, Goddard, Kuhlmann and other psychologists do not consider it necessary that the examiner be a trained psychologist. He should, however, have the psychologic attitude toward the child, and should be properly trained in the use of the tests and how to evaluate the reactions to them. Some people make good examiners and others do not, with the same training. Women, other things being equal, make the best. The situation is somewhat analogous to that of the constructing engineer and the operating engineer of a locomotive. The mechanism is invented and perfected by the psychologists and they have given full instructions as to its use. The examiner must learn the technic and must have the right temperament, especially the faculty of getting the full confidence of the child and securing full and free response. The psychologists can be depended on to remedy any defects discovered in the mechanism.

Already the system is being applied in many public schools, especially in the large cities, either as a regular test for special cases or for making surveys. So much for the system of measuring intelligence.

The physician, naturally conservative, not inclined to be carried away by new "fads," may properly inquire:

1. Why should our profession employ a system of measuring intelligence which at most only deals with "symptoms."

2. Assuming that it will be of service in determining intellectual levels, how is the result to be translated into definite diagnosis or prognosis; in other words, what amount of retardation indicates mental defect?

The symptoms—the functioning of a partially developed mind—are exactly what the physician is after at that point in the history of any given case when the mental tests would be called into requisition. The arresting cause, whether it be a lack of hereditary force in the germ plasm, chemical poison, sepsis, or traumatism, has done its work and the physician is studying the patient as an imperfect human product; hence, the problem is, what is to be done for this patient? What training and development is he capable of? We all know that normal children are capable of learning to act, to think, and to inhibit action, with increasing effectiveness as they increase in age and experience, and, inversely, the amount expected of a child will be proportionately less as its age approximates birth. If, then, the child passes the age of 13 with a markedly retarded mental development, this is recognized as a defect and the intellectual level at which the development stopped will in general determine the educational capacity of the child and will be expressed by his mental age, or the age of a normal child at the time when this ability is found. Thus, these "symptoms," while not pointing to any definite cause or pathologic condition, as might be the case in a type of fever, are an index of the condition that must be known to suggest the treatment and training to be employed.

The next question, as to how much retardation constitutes mental defect, while not answerable with scientific accuracy, does not leave a margin of uncertainty that invalidates the general usefulness of the examinations. Suppose we say arbitrarily that three years' retardation at 13 indicates positive mental defect, this will leave a safe margin, as less retardation usually represents incompetence. The examiner can make a very workable table for practical use based on this assumption, and intended to apply to lower ages. Suppose the retardation be three years at 13, then we may assume for practical purposes that $^{3}/_{13}$ is the constant factor of retardation. At 9 years the retardation would be approximately $2\ ^{1}/_{13}$ years and at 6 years, $1\ ^{5}/_{13}$ years, etc. If a greater retardation is found, it simply means the use of a correspondingly larger factor and a lower mental age.

Now it is not to be understood that this means of determining the retardation at any other age than the one at which the examination is made is scientifically correct. It is only a ready method of making an approximate estimate. Psychologists have not worked out the problem of the rate of the evolution or development of mind in normal children. That is, how it varies in uniformity from birth to 13, nor is it yet ascertained whether there is a definite relation between the normal rate and the retardation rate in mental defectives.

Again, we would not expect that mental retardation from traumatic and possibly other postnatal causes, would follow any rule, because the cortical areas or nerve lines affected would obviously vary greatly. As 60 per cent. to 70 per cent. of all cases of mental defect are probably hereditary, the field for the uses of the tests is not greatly limited by this fact, and they are useful, obviously in acquired cases. Some of these cases in which the cause is traumatic, will show a sudden and complete arrest of development at the time of the accident.

Now as the higher faculties are the last to develop, it is obvious in theory and verified by experience that with one or two years' retardation even, there is usually poor judgment, lack of forethought, weak inhibition in relation to appetites, and in general, lack of capacity and resistance to cope with the social and economic condi-

tions of life, although capable of doing useful work under the guidance of a higher intelligence. With slight retardation, fair success depends entirely on the environment. Education, of course, is to be determined by the intellectual level found to exist and expressed in terms of mental age—temperament or adaptability to different occupations being considered, as with normals. It is the capacity for manual or routine employment, as a result of training that confuses the uninformed as to the nature of mental defect, because the kind of work mental defectives do so well—and which has resulted from education of the existing capacity—has not called for the exercise of higher control faculties that would be necessary in a successful life of independence. It must be remembered that after all the real test is ability to succeed in life; laboratory tests are only to determine whether or not the faculties essential to insure proper reactions to the natural conditions of life are there and available. The person's variations in temperament or reactions to various interests must be reckoned with. For example, the average mental age of fifty boys in one of our farm colonies at Faribault is 6.9. The highest mental age represented is 11. This latter "boy" is 46 years old and can do any kind of work under general supervision required of a farm hand. He has no initiative, and when an assignment has been completed he will sit down and wait for another. He happens to be of a quick temper and he will resent orders from any one but the head of the department. He will milk six or seven cows and do it well, but he is not a good teamster, largely by reason of his temper.

There are two "boys" each with a mental age of 3; one aged 51, does a little work sweeping walks and doing errands, though he cannot talk and of course cannot read, so must carry notes as messages. He will do his sweeping regularly without being told. Of course the whole amount of work done is but little, though it is a sort of an epitome of his whole life. The other 3-year mental-age case can do good work directly under supervision, in digging post-holes and loading posts on wagons, etc., yet if not watched, will walk off aimlessly. A peculiarity about him in the hayfield is that he can spread the hay after the mower, but cannot pitch it.

One "boy," mental age 4, 26 years old, milks six cows night and morning and does it well. He recognizes the time to start by the sound of the signal bell and gets his pails and starts without further instructions. This is the only thing he has learned to do independently, and he is neat and clean.

One "boy," mental age 6, aged 32, handles an ox-team entirely alone, feeding, hitching, driving and caring for them. He does whatever is assigned with a team without direct oversight and sticks to it until completed. He is interested in his work and will go and finish, uninstructed, work left incomplete by any of his comrades.

Most of the teamsters who handle horses on wagons and farm tools are of 6, 7 and 8 years mental age—steady but shiftless, and needing considerable supervision.

Thus defectives of the same mental age react quite differently to the same occupations.

From this it will be better understood that three years' retardation is a safe margin for the average physician to use in diagnosis.

So far, we have considered intellectual levels only. Now, there is another class of cases of mental defect that, strangely enough, are quite often recognized as mentally defective, though the test shows them to be normal intellectually. They do not react normally to their environment, even when this is excellent, either from lack of power to inhibit emotion and action, from lack of ethical conception, or lack of initiative and ambition. There seems to be a lack of coordination between the intellectual and the emotional phases of the mind. As they come to us for examination, the first question raised in each case is, Has this child had a good early training? In many cases the children are orphans and there is good reason to infer that their training has not been good; shifted as they have been from place to place and deprived of an affectionate and sympathetic parental influence, the emotional nature has not always had a healthy and normal development. Notwithstanding this, there are the other cases, by far the most numerous, that under the same environment develop normally, suggesting the probability that there was something fundamentally wrong in the mental makeup of some, at least, of these children. Then there is the occasional case that has had the very best environment and training, including excellent discipline, and yet makes an absolute failure of life and becomes a wreck and even outcast. It seems therefore—these children all developing to be mentally defective—that we have ample justification for recognizing at least one other group of mental defectives than the one before discussed, which is characterized by low intellectual levels that can be determined by the Binet-Simon tests.

This leads us to the subject of classification of defectives, generally, and a word as to the use of the terms. In 1910 the American Association for the Study of the Feeble-Minded, recognizing the importance of the long-neglected standardization of terms, and also recognizing the fact that the application of the system of measuring intelligence to which Goddard had called attention the previous year, had not only made it possible to classify on the basis of mental age, but also would doubtless lead to other differentiations, adopted tentatively, only, a classification of intellectual grades, as follows:

Feeble-minded	Moron	Mental age, 8 to 12
	Imbecile	Mental age, 3 to 7
	Idiot	Mental age, 0 to 2

The whole question of the "moral imbecile," "defective delinquent," and other special and emotive types, was set aside for further consideration.

It seems to me that we are now approaching the time when specific groups must be recognized of those who fail to conform, through developmental defect other than that of the intellect. The psychologic scheme could be completed by naming each group by the defective mental quality, to which non-conformity is due, as "moral deficiency"—lack of ethical conception, "inhibitive deficiency"—lack of power to control one's actions, etc.

It should be noted also that the terms "feeble-mindedness" and "mental deficiency" are equivalent and general. The morons are the higher group of intellectual defectives that can earn their own living under proper conditions; imbeciles, the intermediate group that cannot earn their own living, but can protect themselves from common physical dangers; idiots, the lowest group, that cannot protect themselves from common physical dangers. The term "retardation" is used in two senses, (1) in school work where there is a failure to keep up with the grade, or pedagogic retardation, depending on remedial causes, and, (2) in cases of actual mental defect.

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In conclusion, the purpose of this paper is to urge on the physicians the adoption of the principle of measuring intelligence in all cases of abnormal mentality in children as a part of routine practice. The desirability of early diagnosis of mental deficiency is self-evident, (1) for the information of the physician that he may advise intelligently, (2) for the sake of the parents, who should be wisely guided in their handling of the child, that they may not expect too much and yet may do the practical thing, which is the most economical, and, (3) in the interest of the child, (*a*) that he may neither be neglected at the time when much can be done, nor forced like a hot-house plant to struggle for years in efforts to do things beyond his capacity, and, (*b*) that his limitations may receive protection from the influences that would tend to criminality.

There is no reason now why the physician should not have available a good examiner and make use of this clinical assistance. He can in this way confirm his diagnosis of mental deficiency or disprove the condition, as the case may be, in a large number of cases. The doubtful cases will thus be reduced to a minimum. The Binet-Simon tests, in the hands of a qualified examiner, are practical for the purpose of determining intellectual levels, and no one need hesitate in making them available because of improvements that may be found necessary thereafter, or certain limitations that characterize them in minor details.

Bear in mind that no laboratory method of diagnosing emotive defects is yet available, or, in other words, any method of determining in advance whether or not a child who passes the intellectual tests will succeed in life under ordinary conditions, while, on the other hand, mental defect showing a retardation of intellectual development amounting to three years means failure in life under ordinary conditions.

Psychologists are already making some headway in determining occupational ability by laboratory tests, and this is very suggestive of future possibilities in determining facts of larger prognostic value, by laboratory reactions in the domain of "emotion" and "will."

Of course, the heredity in the case should be taken into consideration, especially when mental defect is found to be slight, or when non-conformity is not associated with intellectual defect or any psychosis.

ABSTRACT OF DISCUSSION

DR. MARY STRONG, Omaha: Before I studied medicine I taught school for about twelve years and had opportunity to observe the various grades of mental defects. Every single one of these children will grow up to be some kind of a degenerate. Alcoholism in one or both parents or the giving of alcohol to children is, of course, a common cause. I have now under my own care quite a number of various grades of degenerates. Most of these children do manual work well, but they are not capable of mental work.

I am attending physician to a rescue home, and at least 25 per cent. of the girls in the home are degenerates. Some are high-grade degenerates. I believe that the prenatal influence of the mother has an influence on the intelligence of the child.

DR. C. F. WAHRER, Fort Madison, Wis.: The early diagnosis of mental deficiency is important. Why? Because this class of persons must ultimately come under municipal supervision, state or national. After we diagnose the cases what shall we do with the patients? Put them into institutions in which they are trained to a semblance of normality so that they can mix with the normal and intermarry and bring down the normal or supernormal to subnormal and keep on producing a race of mental degenerates? Here I believe in the brutal doctrine of "survival of the fittest" and if we, through state or national resources, diagnose these cases and help to educate the children to self-help so that they can get on without the aid of their neighbors, then let us also register them, and when the time comes for certificates of fitness for marriage, and that must mean also fitness for production, we must say that these particular persons cannot marry. If we keep on raising degenerates through propagation of those we already have, we shall eventually have so many that there will not be enough taxable normal persons to keep charge of the abnormal. Humanity bids us to be our brother's keeper, but as we can never hope to make normal beings out of defectives, and as we owe it to the sum total of humanity not to overburden the world with such defectives, so we should well ponder these problems, and not indulge ourselves in pseudohumane efforts that will be as the nursing of vipers in our bosoms. Let us see to it that these classes do not multiply and vitiate the purer streams of life.

DR. A. C. ROGERS, Faribault, Minn.: We understand that about 25 per cent. of criminals are mental defectives. Also a large percentage of prostitutes.

The cold-blooded idea of "survival of the fittest" holds good until it comes to our own children. The wisest solution at present, it seems to me, is the segregation of defectives; put them in communities where they can have interests and are absolutely protected from propagating their kind. Possibly some time we may have to do differently, but at present this seems to be the obvious policy. Sterilization has been advocated and has a definite application, but it has greater limitations than most people imagine.

AMNESIAS OF TOBACCO AND OF MALARIAL ORIGIN

WITH REPORT OF TWO CASES *

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Professor A., an eminent authority on law in a leading university in this city, is a man about 50 years old, of strong intellect and good physique. His family history is negative as to any form of hereditary physical, or probable neurotic transmission. Alcohol can be excluded and, within all reasonable probability, specific infection also. There was no evidence, subjective or objective, of arterial degenerative change; but he has always been a constant excessive smoker of especially selected, strong tobacco for which he has such a predilection that he sends to Porto Rico for it.

At the time of the occurrence of the amnesia which I am about to describe, which dates back seven years, Professor A. was much debilitated as a result of intense mental application, and emotional upheaval due to affairs of a personal character. He had been seeking solace in tobacco.

On the morning of the day in question, Professor A. had given his usual lecture and, after luncheon, indulged as was his custom in several cups of very black coffee. Half an hour afterwards his housekeeper, entering his study, saw the professor's pipe drop from his mouth as he sat motionless, a vacant stare on his face. To her startled interrogation whether he was ill she received no reply, and her repeated efforts to elicit any response or to arouse him to cognizance of his surroundings were of no avail. He impressed her as dazed. Slowly there spread over his countenance the semblance of a quizzical

* Read before Neurological Section of the New York Academy of Medicine, Oct. 14, 1913.

smile; but his eyes were fixed and he seemed bewildered and as if trying to comprehend an unusual situation. It was impossible to get any intelligent response from him; he was as one lost in introspection, seemed incapable of speech, or of comprehending what was said to him, and sat absolutely motionless. This lasted for half an hour. At the end of that period, like one awakening, he asked:

"Have I been ill? Have I had typhoid fever? Where am I? Am I in California?"

He appeared much exhausted and did not answer questions, but continued to express his comprehension of some mental mishappening in the same words, repeated again and again, and appeared too absorbed in apprehension and dismay to give heed to his surroundings. For nearly an hour, in a state of evident perplexity, he kept repeating:

"Where am I? What has happened to me?"

It so happened that Professor A. had an important engagement at 2 o'clock that afternoon, relating to the publication of a lecture. At exactly 1:45 he arose from his chair, went slowly but directly to the telephone, called up the gentleman with whom he had the appointment and expressed his inability to keep it. The conversation finished, the telephone receiver dropped from his hand and he went back to his chair. His housekeeper asked him why he had not allowed her to telephone for him, and he replied:

"I did not telephone! Why should I? I have nothing to 'phone for!"

It afterward transpired that Professor A. forgot immediately that he had telephoned, but the precise and alert subconscious mind was keenly cognizant of this appointment, one of much importance to him.

He continued his questions as to the time of day, the date and the month, and other matters, indicating that he was without recognition of time or place, of his surroundings, or of his own personality.

It became evident that there was now a partial mental clearing and that the real psychologic state was one of incomplete amnesia. Each question asked, though it received a clear reply, was followed by an amnesia for that question and its answer.

I had not treated Professor A. before this illness. When I saw the patient, he had been in this state for some hours. I purposely left the room several times, and each time on returning found that the patient had not retained knowledge of my identity.

This condition remained essentially unchanged for five days and proved full of trying experiences for the patient. He had but little or no memory of the past at this time; for instance, he did not recognize his books, and did not manifest the alert interest in things going on about him that he did in his normal state. He would lie in bed, or sit in a chair, and much of the time his mind remained a blank.

On the morning of the fifth day his housekeeper noted the first evidence of association with the past, when he remarked, on seeing his cap: "That is mine."

He enjoyed his food when brought to him, though he never asked for anything; apparently he was unable to associate the craving of hunger with the ideas of food.

For the following three weeks Professor A. lived almost a vegetative existence. There was really no incoherence, no flight of ideas, no illusions or hallucinations. There was uncertainty and slowness in mental operations, but this was due to the dominating amnesia. The patient could not associate objects, persons, time or place with his past. His environment was strange to him. He was content, however, to remain passive, with almost childlike complacency. He suffered, however, from the distressing momentary amnesia, almost immediately forgetting again what had just been learned.

In the course of about three weeks his memory and his interest in life began gradually to return. Perfect rehabilitation, however, was more or less sudden. It is interesting to note that on the day after his complete recovery, Professor A. went to his classroom and gave, extemporaneously and letter perfect, a lecture he had finished a day previous to his seizure. It seemed that the three weeks' amnesia had had no influence on the acuteness of his mind; that these three weeks had fallen as a unit from his life. There is still only a vague recollection of the occurrences of these three weeks.

It is relevant to note that Professor A. had suffered a rather severe mental shock during the morning of the day during which his illness so acutely began; the experience was of a disagreeable nature and one that he doubtless wished to suppress in memory.

Withdrawal of all tobacco and general rest and nutritional care was the sole treatment. For several years after, periodic excesses in tobacco indulgence were followed by slight amnesic attacks, responding at once to abstinence. I observed that the acute, very intense paroxysms of hemicrania could invariably be ascribed to the same cause, and with these attacks there was often associated a certain manifest slowness in intellectual processes, and at times temporary mixed aphasic symptoms.

A general neurologic examination revealed no abnormal objective symptoms. The psychologic examination, which was at the time incomplete, showed a general sluggishness of mental processes.

The psychic state of Professor A., while showing an apparent general disturbance of ideation, was really one of dissociation, an amnesia which confused the patient. The perceptions were at first keen, but the incoming stimuli effects could not be placed. His inquiry as to whether he was in California is explained by the fact that he had previously held the chair of law in a California university.

It is of interest to note that the thread of normal mental activity was resumed exactly at the point at which it had been broken. The lecture prepared just previous to the dissociation, though not absolutely committed to memory, was, curiously enough, retained with precision in form and substance, though unrecalled until the time of resumption of the associated activity. This detail would not have been possible in the usual uninterrupted routine of daily experience. There is no doubt that the subconscious retains with precision and detail; we have many laboratory experiments in psychology and psychopathology, and even more in clinical observation, to confirm this among many other most interesting and instructive features of subconscious processes.

Miss M., a young, unmarried woman of 27, though somewhat high-strung and of nervous temperament, has a good personal history. She is not hysterical, is intellectual and fond of her work of teaching school. The family history contains only the one relevant feature that her mother suffered from epilepsy and died of malignant disease.

For a few weeks previous to the beginning of the illness in question, Miss M. had been under intense emotional strain. On Sept 9, 1913, on returning from school in the afternoon, after a day of unusual fatigue, she was suffering with severe headache in the occipital region and, apparently for no reason whatever, was seized with an attack of weeping and showed considerable emotional

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reaction, uttering expressions indicative of her uncertainty as to her surroundings. She seemed perplexed as to her own identity and of her relations with her family and other members of the household. At present she vaguely recalls the state of mind at that time. She directed a number of coherent questions to the maid; but, although she received positive replies, immediately repeated these questions, each time forgetting what she had asked before.

Dr. A. D. Dryfoos attended her that evening and found her in a state of marked mental confusion. This was due largely to the fact that memory for the preceding two days was so defective that she was almost completely amnesic. Her mental processes were otherwise normal, though she was highly emotional, but controlled herself fairly well and her responses were intelligent, and thought and ideation but very slightly disturbed. In this, the psychopathologic state had two distinct components.

The doctor had occasion to speak to her about the experiences of the past summer and learned that she had forgotten the greater part of them; also that the events of the previous forty-eight hours had been apparently entirely effaced from her mind. Although she had spent the greater part of the summer at Delaware Water Gap, the name was only vaguely recalled and not associated with any experiences of her own. She could not recall that she had been in school that day, and did not recognize members of her own family, or remember the name of the maid. The temperature was not abnormal.

On the following morning Miss M. arose feeling in splendid health physically and with less mental confusion, although her memory had not been restored. That evening, when I first saw her, she had a temperature of 105. Though her mind was clear, she could not recall the events of the past two days.

The next day, the 11th, there was distinct splenic enlargement and a dichrotic pulse. An examination of the blood by Dr. Dryfoos disclosed the malarial plasmodium in numbers. The history of the case from this time was a typical tertian rise in temperature and general malaise. On these days there was marked mental confusion preceding the rise in temperature by some hours, though the amnesia was continuous long after all malarial symptoms disappeared, and even at present there is only partial restoration. The prodromal symptoms of two days' duration were characterized by partial amnesia.

These amnesias are doubtless true functional conditions, though directly of toxic origin. The case of Professor A. conclusively establishes that. The dissociation in his case was manifestly a functional one; the working of the subconscious was well shown at the moment when the patient arose to go to the telephone at the proper time to postpone an engagement which he had arranged for. Conscious or cognitive memory was suspended. We see allied states in hypnosis and in induced subconscious states.

In the case of Miss M., as in that of Professor A., dissociation was preceded by emotional upheaval. In the one case, the malarial toxin was the directly exciting factor of the dissociation, and in the other, tobacco played this rôle.

In these cases, just what significance the psychanalyst would attach to the experiences that shortly preceded the psychic symptoms, I shall not here discuss. There was effort at suppression. This is hardly relevant, however, and the dissociation can doubtless be fairly attributed to the toxic action of the exogenic poisons.

In the case of Miss M., the patient was seen by a qualified internist who regarded the case as one of typhoid, and I too was at first so impressed. The initial psychic symptoms, though of an unusual character, taken with the splenic enlargement, dicrotic pulse, high temperature and some tympanites, certainly suggested typhoid; the onset of high temperature and the symptoms just mentioned seemed to justify this; only the demonstrated presence of plasmodium made the diagnosis clear. Because of the personal history of the patient's mother, and also because of the personally more or less neurotic temperament of the patient, the essential psychic symptoms being of an emotional nature, the possibility of epilepsy or hysteroepilepsy was to be considered. To my mind this case is an extremely instructive one, especially to the internist.

Many authors describe initial delirium without fever in some of the infectious diseases, though I have not found amnesia observed as a dominant symptom. It is a question, of course, whether these psychic symptoms are due directly to the toxins or to certain changes produced by the micro-organism itself, such as multiple emboli, etc. The true infection delirium psychoses are regarded as arising from the specific toxins of typhoid, malaria, small-pox and rabies, since they are quite independent of pyrexia. In malaria, the characteristic psychosis which initiates the disease, replacing at first the fever, manifests itself in confusion, flight of ideas, hallucinations, anxiety, evanescent delusions and impulsive movements. It occurs most frequently with the quartan type.

According to some writers, the usual initial delirium of typhoid is of distinct character. It may be like that seen in malaria, or one attended by distinct and formulated persecutory delusions and by hallucinations. Amnesia is not mentioned in the cases I have seen recorded. I believe that when the usual malarial manifestations are represented by the psychic equivalent, we find a neuropathic soil.

Perointzky's findings in pernicious forms of malaria indicate the organic changes that the toxin can produce in the central nervous system. In the cerebrum and cerebellum there are marked hyperemia of the pia vessels, subarachnoid perivascular and pericellular spaces, and obstruction of the capillaries, their endothelium being swollen with masses of changed red blood-cells which slowly pass through the capillaries owing to their increase in size and decrease in elasticity, temporarily causing complete thrombosis. These circulatory disturbances lead to punctiform hemorrhages in the gray matter and at the boundary of the white brain substance and to degenerative and necrotic processes in the brain-cells. According to some writers, the cerebral symptoms are due to capillary emboli formed by parasites, as well as to the action of toxins.

Six cases of motor aphasia are reported by Mine, and Borne reports a case of trismus and one of tetany which he ascribes to the toxic action of the tertian malarial type. Bulbar symptoms are described and one case of left hypoglossus paresis, dysarthria and ataxia of the left arm. A severe case of isolated motor aphasia as a sequel to malaria in a European resident of East Africa is reported. Temporary aphasia followed each attack of the malarial paroxysm and, although the latter subsided in the course of time, the aphasia persisted. A malaria parasite thrombosis, or an embolism in the brain capillaries is assumed, producing a permanent lesion.

That the malarial toxin can give rise to disturbances in an interim during which no parasites or other malarial manifestations are evident and show a peculiarly select-

ive site, is shown by the case described by Forli. The patient had suffered from severe malarial infection, though free from symptoms and parasites at the time of the nervous symptoms. The case is of importance because postmalarial nervous disturbances of cerebral origin are uncommon. Other etiologic factors appear to have been excluded. The onset of vertigo, vomiting, ataxia, asthenia, muscular hypotonus and nystagmus fifteen days after the last paroxysm of malaria is referred by Forli to the specific toxin. He asserts positively that he excluded mechanical circulatory disturbances as a cause.

In severe cases of malarial infection, during the Spanish-American War, I had occasion to examine at a later date some psychic manifestations that were evidently equivalents of the malarial paroxysm. These were brought to my attention during my service as U. S. examining surgeon. In those cases, as I recall them, maniacal states of weeks' or several months' duration characterized the picture. I remember that the intellectual faculties, according to histories given, were much disturbed, though the patient could give a fairly clear account of his condition after recovery.

Regis, on the other hand, says that the psychic disturbances noted in the cases of chronic malarial infection are followed by amnesia; he also finds mania the predominant state. According to the same author, the psychic disturbances during the usual attacks of the malarial plasmodium actively resemble those of acute alcoholism, while the psychic phenomena of the interval are analogous to those of the chronic form.

As is well known, malarial manifestations, like those of syphilis, are prone to appear at times when there is reduction of resistance in the economy. For example, the accoucheur is often confronted with the characteristic pyrexia, etc., in women who have suffered previously with malaria. There is a depletion of the system incidental to childbearing. Again, symptoms of malarial origin obstruct the clinical picture, often after traumas, and this is especially true in regard to severe traumas of the central nervous system.

In several of the cases which I saw after the Spanish-American War in which there were profound psychic disturbances, postmalarial, there was a head trauma as a direct etiologic factor. Literature affords instances of cases of similar nature; but a review of literature indicates the paucity of recorded cases of true amnesia either in nicotin poisoning or in malarial infection.

The case of Professor A. is most unusual, and that of Miss M., if regarded as a prodromal stage of malaria, is rarer. The symptoms of tobacco intoxication, or of its essential oil, nicotin, are variously described. I shall deal only with its effects on the nervous system and, more particularly, with psychic manifestations. A pure amnesia, as in the case of Professor A., I have been unable to find described.

Experimental investigations on the effect of nicotin in the lower animals have led to positive findings in the nervous system. Vas fed rabbits for a prolonged period with increasing doses of nicotin up to 2½ grains daily. He found hemoglobin diminished in six weeks to 40 per cent., with red cells proportionately decreased, bodyweight and alkalinity of blood diminished. Histologically, marked cell changes in the nervous system were demonstrated in the anterior horns, spinal and sympathetic ganglia. These findings fairly represent those generally described.

In general the familiar functional symptoms in man are sensation of pressure in the head, vertigo, somnolence, disturbed capacity for intellectual effort, abnormal moods, amblyopic symptoms, neuralgia and mydriasis, uncertainty of movement, a form of ataxia, tremor, muscular contractions, irregularity of heart action, or palpitation, emaciation, etc. I have seen bradycardia. Hyperesthesia of the acoustic is described. Aboulia, semistuporous states, insomnia, failure of memory, transitory aphasia, disturbance of judgment and agoraphobia are frequently recorded in cases of tobacco poisoning.

As to the phobias occasionally referred to as the result of tobacco intoxication, I have under observation two cases that are illuminating. Mr. H. W., after very excessive indulgence for some years, with a sudden marked increase in the daily number of cigarettes, was seized with palpitation, irregularity of heart action and precordial distress. He is a young man of about 30 and of neuropathic constitution. Withdrawal of the tobacco and rest restored him in a few weeks. On going out for the first time after his attack, he was seized with the common fear on crossing the street and soon developed the morbid apprehension characteristic of agoraphobia. One would be strongly inclined to attribute this solely to tobacco and I do not doubt that the nicotin was an exciting factor in the neurosis; but this fear neurosis continued although the nicotin had been entirely given up. Two years later I saw the patient, and psychanalysis gave the direct though remote etiologic factor, a suppressed psychic trauma. The patient recovered almost immediately through treatment by familiar psychic methods.

The aphasias are usually of a transitory character, coming on in attacks lasting from fifteen to thirty minutes, and are characterized particularly by the forgetting of names. A prolonged motor or sensory aphasia, not explained by other more evident causes, is not described.

A true and characteristic psychosis, having origin in tobacco intoxication, is fairly well established. Competent authors, such as Kjellberg, Schwartz, Frankl-Hochwart and others have observed it. Kjellberg speaks of a primary paranoid psychosis observed at the Upsala Asylum. The similarity of the symptoms points to a common etiology; they were observed only in very excessive users of tobacco. Whether or not this true psychosis can be unquestionably attributed to nicotin poisoning as a sole etiologic factor is perhaps open to question. Since, however, certain definite forms of functional psychic symptoms may be with certainty ascribed to nicotin, it is but reasonable that especially susceptible individuals, those intolerant by reason of neuropathic predisposition, should become more seriously affected by excessive and constant use of the poison. It is to be observed that the true psychosis described is invariably found in excessive and prolonged users of tobacco, and among these only when there is an unusual physical or mental strain, such as intense emotion and acute intensity in the use of the weed. The characteristic psychologic features may be divided into three stages, and these seem to be quite distinct from the various neurasthenic symptoms of nicotin poisoning. Kjellberg and Frankl-Hochwart seem to have made similar observations, and scattered through the literature are the reports of cases fitting into the groups as defined by these authors.

The patient experiences distressing sensations of weakness and incapacity for effort, and true hallucinations and suicidal tendencies follow. A prodromal stage initiates this nicotinosis mentalis and is succeeded by three distinct periods unless it terminates promptly in recovery. The prodromal stage is the one which should be recognized if the patient is to be spared a long period

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of mental anguish. These initial manifestations consist of general and apparently unaccountable wretchedness. There is change of disposition, and restlessness at night, finally becoming obstinate insomnia. The patient suddenly finds his work distasteful, although he struggles on; there is tendency to brood, and often to turn to thoughts of religion which later form the basis of illusions and pathologic imagery. The insomnia and psychic depression increase temporarily, and attacks of precordial distress with palpitation appear. At the end of from six weeks to three months the actual psychosis abruptly manifests itself. The patient is dominated by hallucinations; visions of a religious character appear; there are imperative concepts and fixed ideas, often associated with suicidal tendencies. There is marked depression; a feeling of great weariness and exhaustion. There are brief attacks of indefinite fear, during which acts of violence may be committed; otherwise, the patient is quiet and obedient. He speaks only on request, but gives reasonable answers to questions. Nutrition is maintained and the appetite is good. After six or seven months recovery begins, or the disease enters into a new stage. The depression changes to a state of exaltation. The patient speaks freely of what he describes as visions, such as visits of angels and other visual and auditory hallucinations. These periods usually last from two to three weeks with indefinite intervals during which the patient is discontented and gloomy and his hallucinations take a depressing form, although the patient speaks distinctly and otherwise intelligently. This stage may extend over an indefinite period; unless recovery ensues it passes into the third, the terminal stage of the disease. In this last phase of the nicotin psychosis there is a blending of the symptoms. The periods of euphoria gradually subside; the patient's mentality becomes blurred and seriously impaired. There are defects of memory, though the patient does not become indifferent to his surroundings. He becomes taciturn, speaks only on urgent request; his answers are brief, but now not always logical, though distinct and well articulated. The expression is vacant, and often there is rapid, compulsory movement.

The prognosis may be said to be favorable when the patient comes under treatment in the incipient stage and is entirely deprived of tobacco. A cure is then said to result within six months. Some authorities regard recovery as almost certain in the second stage, though a year may elapse before the pathologic periods disappear entirely.

Kjellberg knew of no instance of recovery from the third stage.

Frankl-Hochwart and others establish a remarkable number and variety of relations between the abuse of nicotin and nervous complexes not heretofore ascribed to this etiology, such as disturbances of apparently meningeal character, as well as aphasia, hemiparesis and intense and persistent neuralgia. Intermittent claudication, together with the classic nervous sequelae of nicotin abuse are included in what is described as the spinal-peripheral type. With special reference to the cerebral form, there is noted, among very excessive smokers, a premature mental weakness, a kind of senility, at an age around 50 when such changes are infrequent. There is no extreme dementia, but rather a certain reduction of the mental horizon and a distinct decrease of energy. These conditions seem to constitute a transition to the true tobacco psychosis. True disturbances of consciousness are uncommon, though a peculiar clouding of the intellect, lasting for a few moments, is described. Distressing failure of memory is recorded, while in some cases purely neurasthenic absence of mind was noted. For example: a physician, a healthy man of 31, whose first attempt at smoking began at 5 years of age and who finally became a very excessive smoker, noted suddenly, in his twenty-eighth year, that his memory for names became very deficient and he developed a tremor. The symptoms disappeared with a reduction of the quantity of cigarettes, to appear again immediately when the allowance of cigarettes was increased.

Frankl-Hochwart cites the case of a physician aged 40, also a great smoker of cigarettes, whose memory had become so defective as to lead to the commission of serious errors in practice. With the discontinuation of tobacco, a permanent cure was effected in a few months.

Some writers observe that memory defects, in greater or less degree, are likely to persist even after the disappearance of other manifestations.

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A CASE OF APPARENT FOOD-POISONING OF THE TYPE KNOWN AS BOTULISM OR ALLANTIASIS

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Food-poisoning of a narcotic type must be rare as compared with the form familiarly associated with the term ptomain. Intense pain, violent vomiting, and exhausting diarrhea—frequently attended with high fever—are the usual symptoms. Strongly contrasted with these relatively common cases are those in which there is little or no pain, no significant temperature, but a profound complex of disturbances affecting the higher nerve-centers. In a few instances a picture like this has been observed where the offending food was the mussel, a mollusc believed to develop a specific poison, mytilotoxin, under the influence of certain organisms.

Sausage-poisoning, botulism, or allantiasis is another intoxication following the eating of protein food decomposed by *Bacillus botulinus*. A few hundred cases have been recorded with mortality approaching 40 per cent. Sausage has been the cause of the great majority, but other articles of diet have been implicated. The following personal experience may be worth transcribing because of its close resemblance to Sheppard's cases[1] and because little has been said of the protracted convalescence after such attacks.

Monday, May 5, 1913, I went to lunch with two friends at a first-class restaurant. The meal consisted of minced chicken on toast, mashed potato, and coffee-jelly with whipped cream. My friends did not eat these dishes. I left the restaurant about 1:45 and returned to Simmons College, where I conducted a recitation in the period between 2:35 and 3:25. During this exercise I became conscious of a growing inertia. In the final ten minutes I held myself to my task with extreme difficulty. After a momentary sensation of flushing, I

1. Bolduan: Food-Poisoning, Treat and Co., New York, 1909, Chapter 3. The cases may be briefly recalled. Three young men camping in California ate canned pork and beans. In eighteen hours they became ill and all died on the fourth day. Confusion of vision was the earliest symptom, which was soon followed by aphonia, dysphagia, and distressing accumulations of mucus in the pharynx. Muscular power failed steadily and breathing became difficult. Exertion greatly accelerated the heart. The temperature was normal or subnormal. Constipation was stubborn but there was a fair secretion of urine. To the last the mental condition was notably clear. Some of this poisonous food, given to chickens, killed nine out of twelve of those eating it.

reacted to chilliness and began to sway on my feet. At the same time I became conscious of a curious hyperesthesia of the pharynx so great that the passing of each breath was distinctly felt.

Within a few minutes after the dismissal of the class my faintness led me to make my way most unsteadily to a lavatory where I was soon compelled to lie at full length on the floor. An attempt to sit up after an interval of rest brought streams of cold sweat and a feeling of utter helplessness. I was soon found by my colleagues and a couch was provided for me. Here I lay until about 5:30 without marked symptoms other than the persisting faintness. A sudden onset of nausea with scant vomiting then occurred. The material vomited at this time and later appeared to consist almost wholly of chicken unaltered by its stay in the stomach and scarcely acidified. The taste was characteristic and might be described as rough, rancid, or acrid; as in the description given by Bolduan[2] of ham affected by *B. botulinus*. About 6 o'clock I was seen by a physician who diagnosed the case as a transient gastric indigestion and gave peppermint and strychnin, predicting that I could soon walk to the car. Immediately after his departure there was copious but not distressing vomiting. Toward 8 o'clock, as I did not recover from the prostration, an automobile was secured and I was prepared for the journey home. A third sharp attack of vomiting occurred when I sat up. Vertigo and nystagmus developed in a startling degree, the car seemed to be ascending an endless spiral, the stars made circles in the sky, and the houses by the wayside reeled. The lighted doorway of my house seemed to approach and surround me as I was carried in. My bed for the moment presented itself as a vertical surface which I could not conceive to be a resting-place. My family doctor was called and prescribed strychnin. I passed a night of relative comfort, though the sleep was light.

Tuesday morning, May 6, the most conspicuous symptom was the inadequate and intermittent heart-action. This, which the physician considered somewhat alarming, improved under treatment and was not noticeable to me after a few hours. Subjectively the cardiac irregularity was far less distressing than the vertigo and nystagmus. Whenever I opened my eyes on this day the impression of gyration of the room was appalling. I could change the position of my legs without much discomfort, but to turn my head even very slowly from one side to the other brought an accession of the overpowering giddiness. Cathartics and an enema secured an evacuation in the afternoon. Vomiting of chicken, which seemed entirely unchanged, recurred at the same time, and showed that the stomach had not been emptied the day before. Later the first urine in more than twenty-four hours was passed; vesical tone was evidently very deficient.

I gained strength gradually during the next few days and the vertigo diminished, though it remained severe. Thursday evening I stood and found that ataxia existed to such an extent that I could scarcely keep my feet. My first walks were extremely unsteady and were accompanied by dizziness and confused vision. Still I covered a half mile on Sunday, May 11, and next day went to the college for a short time. I now ceased taking the strychnin, and it is probable that the symptoms which then appeared had previously been held in abeyance. Monday night I woke at midnight, and found that my voice was nearly inaudible and that the prostration and vertigo had again become serious. Tuesday, May 13, was perhaps the most wretched day of my illness. There was great difficulty in speaking and in swallowing. Solid food returned from the pharynx and there were spasmodic contractions of the diaphragm. Mucus, which came in quantities into my mouth, had to be swept out with the finger. The nystagmus now became limited to momentary onsets, but in its place I became aware of a peculiar diplopia. The image on one retina was not merely displaced from the position of its fellow but was tilted about 15 degrees from parallel. Abnormal innervation of the oblique muscles on one side would seem to be implied. This fantastic diplopia gradually gave place to the familiar variety and this occurred less and less often as my convalescence proceeded.

From May 13 my recovery pursued a course which was disheartenlingly slow but free from any setbacks. Among the persistent symptoms were constipation with discomfort in the region of the sigmoid, greatly lessened urinary secretion, burning in the throat, a rancid taste in the mouth, grotesque but diminishing ataxia, and the visual difficulties mentioned. The left pupil was usually smaller than the right[3] and I thought I detected a slight failure to relax accommodation with the left eye. Reading was difficult for several weeks and the ability to write, as requiring closer fixation, was still longer in returning. I went to New Hampshire June 21, and by diligent effort recovered my normal walking power. July 11 I was able to do 34 miles. All summer I perspired excessively and was short of breath. My appetite and digestion steadily improved.

The mental condition from first to last was characterized by clearness and a disposition to a calm observation of my own case. The power of application was naturally limited but there was no difficulty with memory when the effort was brief. I have to confess to a display of irritability when unable to speak clearly, which was precisely like that in Sheppard's fatal cases.

It could not be discovered that any other cases of poisoning were reported to the proprietors of the restaurant. It is worth noting that my disaster occurred on Monday. The restaurant is closed on Sunday and any meat prepared for serving in another form and warmed over to appear as an entrée would have lain twice as long as usual before the Monday dinner. It is stated that liver is a favorite medium for the growth of *B. botulinus*, and it is not unreasonable to suppose that an infection might be focal in a single organ and be served as in giblets to but one person. An anaërobe like this one would develop within a piece of meat much more readily than it would pass from one flake to another. The anomalous feature in my case is the short interval between the meal and the full toxic effect—three hours instead of twelve to twenty-four.

2. Bolduan: Quoted from Van Ermengem, the discoverer of *B. botulinus*, Ztschr. f. Hyg., 1897, xxvi, 1.

3. Unequal pupils have been noticed in animals poisoned with the toxin of *B. botulinus*. Post-mortem examinations of animals dead from this cause show degenerative changes in the gray matter of the medulla and in the nuclei of the oculomotor nerves.

BURN OF EYES FROM CONTENTS OF GOLF-BALL CORE

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During the last few years cases of severe, permanent injury due to corneal and conjunctival burns have been reported from all over the country. The burns referred to have been caused by the liquid contained in the small rubber core of certain golf-balls, which have been cut open by curious children. Almost invariably the history is that some child finds an old golf-ball with its covering partly off. He removes the rest of the cover and rubber and then comes to the core ball; this he bounces until it bursts, or punctures it with a knife. The contained fluid spurts out onto his clothing and into his eyes.

There are apparently two makes of golf-balls on the market, each containing a different, highly caustic substance. Dr. R. L. Emerson of Boston very kindly analyzed the semifluid mass contained in one of the golf-balls, said to be of similar make to those causing these burns, and found it to contain a mixture of barium sulphate, soap, and a free alkali, probably the same mixture as that reported by Dr. Crigler.[1] Balls of another make have been found to contain a solution in which there is zinc chlorid.

About April 3 or 4 two of such burn cases came under my care on the same day; the patients were boys, aged about 12. At this time these cases were brought to the notice of the state board of health, and a bill was introduced into the legis-

1. Crigler, L. W.: Burn of Eyeball Due to Caustic Contents of Golf-Ball, THE JOURNAL A. M. A., April 26, 1913, p. 1297.

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lature to prohibit the sale of golf-balls which contained any caustic fluid. The United States Golf Association issued a warning to all persons against the dangerous practice of cutting open golf-balls. It was thought because of the publicity given this danger that further warning would be superfluous. Within the last few weeks, however, three additional accidents due to the opening of golf-ball cores have occurred near Boston. It seems wise, because of the repeated recurrences of these accidents, again to call the attention of parents to this dangerous practice. The following four cases are typical:

Ruth S., aged 9, Sept. 1, 1911, was admitted as a house patient to the Massachusetts Charitable Eye and Ear Infirmary. Three days previous, while she was cutting open a golf-ball core, the contents spurted into the left eye. Vision in right eye was normal; vision in left eye was not obtained, there being so much chemosis and swelling of the conjunctiva, more marked below. The lower fornix was practically obliterated; cornea was diffusely whitish and hazy. September 3, corneal condition was the same, but there was marked hypopyon filling about one-third of the anterior chamber. The Saemisch operation was done. On September 8 cornea was clearer above and hypopyon had somewhat decreased. October 12 the cornea was only a little clearer, hypopyon had disappeared, and there was only slight circumcorneal injection. October 14 the case was discharged; vision in the right eye had not been affected; vision in the left eye, according to the hospital record, was nil.

Lillian S., aged 11, Oct. 23, 1912, was admitted as a house patient to the infirmary. Previous to this she was treated by a local physician. On October 19, while she was playing with a golf-ball core, it ruptured and contents spurted into her right eye. When first seen the upper lid was bound down to the cornea with cicatricial tissues which extended the whole length of the lid and was attached below to the lower margin of the cornea. There was much pain and photophobia. The lid was peeled from the cornea and Cargile membrane covered over the conjunctival surface. On October 28 there was some swelling of the conjunctiva and lids; the cornea was still hazy and the pupil well dilated. The child when seen at her home in June, had vision in the injured right eye of 20/200. The cornea was fairly clear toward the periphery, with a very marked central haze.

George J., aged 13, April 11, 1913, was admitted as a house patient to the infirmary. Three days previous he opened a golf-ball core with his jack-knife. His face was not more than a foot from the ball when he opened it and the fluid squirted into his right eye. In this case the lid was not adherent to the cornea. When first seen neither the corneal tissue nor the iris could be made out; the whole eye looked as though it was covered by a diphtheritic membrane. There was considerable pain, photophobia, and swelling of conjunctiva and lids. For ten days the condition remained about the same in spite of the usual treatment. On about the twelfth day the whitish membrane had disappeared, leaving the outer third of the cornea clear. Hypopyon appeared about the sixteenth day and the Saemisch operation was done. When he left the hospital on May 29, his vision in the good eye was normal; in the right eye, shadows. October 4 his vision was about 20/200 plus in the right eye. The eye was white and quiet. The outer third and upper fourth of the cornea was clear; the rest was densely leukomatous. There was a large symblepharon from lower corneal margin to lower fornix.

Stewart F., aged 12, was bouncing a golf-ball core April 10, 1913; it burst and the contained fluid flew into his face and eyes. The next day the cornea in the right eye was slightly hazy centrally; cornea in the left eye was clear. Considerable photophobia, swelling of lids and conjunctival injection in both eyes. Face was slightly burned around his chin. The left eye became white and quiet in a short time. The right eye cleared up rapidly and on April 14 the cornea was clear. The burn was apparently most superficial, the deep corneal tissue not being invaded as it was in the foregoing cases. The fortunate outcome of this case was undoubtedly due to the distance of the ball from the eyes, the greater part of the fluid striking his coat.

Of these four patients only one escaped permanent injury, while the other three each practically lost the use of one eye.

It can be seen from the cases reported how serious such accidents may be, and how necessary it is that parents and children should be warned against this danger.

101 Newbury Street.

QUININ AND UREA HYDROCHLORID IN THE TREATMENT OF SCIATICA

H. A. CABLES, B.S., M.D., EAST ST. LOUIS, ILL.

During 1913 I have treated eight cases of sciatica. In one case the anterior crural as well as the sciatic nerve was involved. These cases were all treated by hypodermic injections of a 4 per cent. solution of quinin and urea hydrochlorid in a normal salt solution into the subcutaneous tissue over the course of the nerves. No attempt was made to inject the nerve. The skin was washed thoroughly with 65 per cent. alcohol. There were fifty injections in all with no untoward result other than the little soreness that always follows any hypodermic injection. Seven patients received six injections each, and one received eight.

Eight months have elapsed since the first case was treated and in none has there been a return of the attack. All the patients experienced decided relief within a short time after the first treatment and none had a severe attack after the third. The injections were given daily for four doses, and then every other day until the patients were entirely relieved of the attack. The duration, prior to beginning injections, varied from thirteen weeks in one, and eight in another, to one week. In many of these cases resort had been made to the use of morphin in order that the patient might obtain rest. Half of the patients had been treated by other physicians for variable lengths of time.

It was owing to a determination not to use morphin that I used quinin and urea hydrochlorid. The patient was a man, aged 55. The duration of the attack at the time of beginning injections was eight weeks. The left leg was the one affected. The patient unintentionally blistered the skin from the hip to the knee in an effort to relieve himself. Medication was as varied as there are remedies recommended for the complaint, with the exception that morphin had not been given. The first injection was given at 2 p. m. and the patient had a comfortable night. Six injections were given in the eight days, when the patient returned to his work and has continued for eight months. Three of the series were women and all were past 40 years of age. The oldest was 63 and the youngest 42. No other medication was used in any of the cases except the first, and none other used on this patient after beginning the injections.

I make this report that others may try the method and thus determine whether or not it has any real merit. I have had no opportunity to try it in facial or orbital neuralgias, but believe it would be equally as efficacious.

Since I wrote this report a physician, at my suggestion, treated two cases of facial neuralgia with complete relief following second injection.

Food and the Cost of Living.—Because of the abundance of our food-supply we have hitherto been not only well fed but actually prodigal, or even wasteful of our resources. At last, however, the unthinking multitude is reminded by the pinch of the universal high cost of living that it is no longer possible for everybody in America to have everything he wants. It has been well said that the trouble is not so much with the high cost of living as with the cost of high living, and this clever epigram certainly covers a multitude of sins. Extravagance probably plays an important part in the present unhappiness, and yet we have little reason to suppose that in proportion to the population there was not nearly, if not quite, as much extravagance twenty years ago as there is today.—William T. Sedgwick, *Am. Jour. Pub. Health.*

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

535 NORTH DEARBORN STREET . . . CHICAGO, ILL.

Cable Address . . . . . "Medic, Chicago"

Subscription price . . . . . Five dollars per annum in advance

Contributors, subscribers and readers will find important information on the second advertising page following the reading-matter.

SATURDAY, DECEMBER 27, 1913

On account of the large amount of space occupied by the index in this issue of THE JOURNAL, certain departments have been omitted entirely and others abbreviated.

THE INDEX

This issue of the THE JOURNAL contains the index to the current, or sixty-first, volume of THE JOURNAL, including the current medical literature which has been listed from week to week. The Index contains references to original articles in over two hundred of the leading medical journals of the world, including those of the principal foreign countries.

The Index consists of two parts — an author and a subject index. Under "Authors" appear the names of all who have contributed articles to THE JOURNAL or to any other medical journal listed in the current literature, as well as the names of those whose papers are abstracted in the medical society reports in THE JOURNAL. Under "Subjects" will be found complete references to all reading-matter in THE JOURNAL and references to the original articles in all domestic and foreign journals listed, arranged under the subject of the article with double entry when necessary and with numerous cross-references to facilitate the use of the Index. The figures in bold-faced type refer to reading-matter in THE JOURNAL.

The "Guide to Current Medical Literature," under which title the Index appears in pamphlet form,[1] contains, in addition, the titles of the articles listed, arranged chronologically and by journals, as in the Current Medical Literature Department. It is issued in separate form for convenience—to make it unnecessary to handle the bound volume of THE JOURNAL.

Just preceding the Index a list of the journals indexed during the past six months is given. Any foreign journal, except those starred, will be lent by THE JOURNAL to subscribers and members in the United States with the understanding that it will not be held over three days. Requests for journals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. The addresses of the domestic journals are given, and these can be obtained direct from the publishers. No domestic journal will be lent, as these can be obtained direct from the publishers as easily and as quickly as from us.

1. The Guide to Current Medical Literature may be obtained from the Association office at 50 cents a copy.

THE GROWTH OF MEDICAL LITERATURE

In his introductory address before the annual meeting of the German Congress for Internal Medicine for 1913, Penzoldt of Erlangen offered some sound and timely advice relating to the situations created by the enormous growth of medical literature in recent years.[1] This eminent German teacher, while expressing his regret at the growing dispersion of internal medicine into a galaxy of medical "specialties" with its danger of depriving the physician of the coming decade of the helpful point of view which comes from a more comprehensive and synthetic treatment of the manifestations of disease, frankly admits that we cannot stem the tide of the prevailing tendency. One way of modifying it is to direct attention to some of the contributory influences. Among these the tremendous multiplication of published records, contributions and reviews in the field of medicine has made it necessary for the individual to confine his attention to special groups, if he would master even a modicum of what the printing-presses turn out.

How shall one account for this excessive zeal in publication? In a lecture before the Royal Institution in London, Dr. Plummer[2] bemoaned the floods of work that are being poured into journals, annals, proceedings, etc., some of it of the best, with much of it that is temporary, indifferent and bad; so that at times it seems as if some branches of science were in danger of being "smothered in the dust of its own workshop, or drowned in the waters of its own activity." We do not, nowadays, he adds, keep our ideas and scraps of work to ourselves until they are either established, or, as is more likely, dissipated; so we have a huge mass of what is called "literature," filled with many trivial, fragmentary and doubtful generalizations, many of which we have with pain and trouble to sweep into the dust-bin, Nature's blessed mortmain law taking too long to act.

It is, however, of little avail to inveigh against the current practices. We must analyze the cause of the excessive zeal for publication. Penzoldt has well said that every good physician must be an industrious investigator, for each patient brings new problems; but it is by no means essential that every detail in his modest, quiet field of research be thrust into public print. Fortunately, it is not the hope of direct monetary reward or compensation, but rather a natural, justifiable ambition and a healthy competition that calls forth the

1. Penzoldt, F.: Verhandl. d. Kong. f. inn. Med., 1913, xxx, 1.
2. Plummer, H. G.: Blood Parasites, Science, Nov. 21, 1913, p. 724.

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literary effort of medical men in most instances. We cannot impugn such honorable motives; nevertheless the time has come to call a halt on the endless enumeration of case histories and all of the other manifold features which characterize the ordinary contributions to the medical journals of the present day. There ought to be a wider inculcation of the principle that the index of accomplishment in the individual is not the number or diversity or prompt succession of his contributions, but rather their comprehensive spirit and fundamental excellence. If the publications of the medical profession were subjected to the same intensive and rigid critique that is applied in some other departments of literary effort, the volume of hasty output, of incomplete evidence, of uncorrelated findings and unjustified generalizations would become smaller.

Not alone the competition among men, but also the rivalry of journals contributes to the perpetuation of the habit of unnecessary publication. The manuscript which a critical editor with high standards of excellence rejects or advises to be modified — often to the obvious ultimate benefit of the author as well as the science involved — speedily finds its way, not into the waste-basket, but into another of the almost endless number of medical journals competing for professional favor.

Sooner or later a policy of frank, unrelenting editorial scrutiny must be adopted on a broad scale in medical journalism and scientific publications in general. The beginnings have scarcely been ventured as yet; but when a real quality standard, unyielding to the individual, unconscious of personal relationships and preferences and indifferent to offhand criticism, is once firmly put into practice, many of the abuses will remedy themselves and much of the surplus of worthless trivialities will be eliminated by a healthy growth of sentiment favorable to an abridgment of the current flood of papers. Then, in turn, the field of medical research will appear more homogeneous and be more easily surveyed than it is at present.

THE PRODUCTION OF ANIMAL HEAT

Since Rubner's fundamental experiments[1] in relation to the long-standing problem of the source of animal heat, the conclusions which he reached regarding the equivalence of the heat actually produced in the animal body and the amount computed from the catabolism have been verified by others. Most important among these corroboratory studies, which demonstrated that the law of the conservation of energy finds a strict application in the animal body as well as in the inanimate world about us, are the widely known researches of Atwater and Benedict,[2] which established beyond a reasonable doubt that in man as well as in the carnivora the same equivalences between chemical energy, heat energy and mechanical energy obtain as elsewhere.

Although there is no reason to believe that the fundamental nutritive processes in herbivora are essentially different from those which exist in the carnivora and omnivora, the character of their digestive processes, involving as they do quite distinct types of foods along with the pronounced participation of bacterial activities, has always made direct investigations on herbivorous animals, and particularly on ruminants, appear desirable. It must be borne in mind that this group of animals experiences extensive fermentation of carbohydrates, especially in the capacious first stomach, with the production of large amounts of carbon dioxid, methane and sometimes hydrogen. Furthermore, the urinary end-products are also distinctive, including, in addition to hippuric acid, notable quantities of ammonia and more or less organic matter of unknown nature.

For some years the desired experiments have been conducted at the Institute of Animal Nutrition of the Pennsylvania State College under the leadership of H. P. Armsby. Few who have not engaged in comparable experimental work can realize the numerous sources of error and appreciate the necessary precautions which such undertakings entail. It is gratifying to note, therefore, that a total of fifty-seven experiments conducted in the past ten years have verified the expected result. The differences between the calculated and observed heat production in twenty-four hours in the total of all these numerous trials is only 0.4 per cent.—truly a close agreement.[3] The outcome is a credit to American science. It has an importance in its economic aspect as well as from a physiologic point of view. Agricultural animals are transformers of chemical energy, storing up portions of it in forms available for man's nutrition. The fundamental laws governing these transformations have now been firmly established, thanks to the energy of our American workers and the liberality with which their researches have been endowed.

SUNLIGHT AND ORGANIC SYNTHESIS

Our English scientific colleagues, apparently mindful of the dictum that the goal of science is nothing short of the complete interpretation of the universe, have of late been busily and almost acrimoniously engaged in a discussion of the origin of life. Few of us who are absorbed in the busy occupations of an eminently practical profession stop to consider what must be, or have been, "the first stage in the evolution of organic from inorganic matter at the dawning of life in a world hitherto devoid of anything organic."[1] When, however, the possibilities of this first primeval step are presented

1. Rubner, M.: Ztschr. f. Biol., 1894, xxx. 73.
2. Atwater, W. O., and Benedict, F. G.: U. S. Dept. Agriculture, Office of Expt. Stations, Bulls. 109 and 136; Mem. Nat. Acad. Sc., viii. 1255. For herbivora see also Laulanie: Arch. de physiol. norm. et path., 1898, p. 748.
3. Armsby, H. P.: A Comparison of the Observed and Computed Heat Production of Cattle, Jour. Am. Chem. Soc., 1913, xxxv. 1794.
1. Speculations in this field are presented in an entertaining way by Moore, B.: The Origin and Nature of Life, Williams and Norgate, London, 1912.

in terms of simple reactions which all of us can appreciate, the pleasure of speculation finds ready devotees in the members of the medical profession; for when one, like a physician, is dealing day after day with the behavior of protoplasm in both its normal and its pathologic manifestations, he is likely at some time in a moment of exalted inspiration to ask himself some of these fundamental questions as to its origin.

In the vegetable kingdom we already recognize in chlorophyl, the green coloring-matter of plants, a substance capable of acting as a transformer of light-energy whereby the synthesis of organic from inorganic matter takes place. The distinguished chemist Baeyer long ago suggested that the initial stage in the synthesis of organic from inorganic matter by the green plant consists in a reaction of such simple compounds as carbon dioxid and water to produce formaldehyd and oxygen:

$$CO_2 + H_2O \rightarrow H \cdot CHO + O_2$$

The external energy which is necessary in any such transformation, because the reacting substances — carbon dioxid and water — are fully oxidized and must be reduced with evolution of oxygen and uptake of energy in what is termed an endothermic reaction, can be supplied from the energy of light vibrations. The formaldehyd is actually known to be thus formed; but in view of its toxicity it does not accumulate as such in the plant, being rapidly converted into more complex substances — possibly to carbohydrates.

Chlorophyl and its analogues are themselves highly complex organic substances and merely serve to push the inquiry a step backward. It has been necessary to search for processes in which the beginnings shall be confined solely to reactions in the inorganic world, under conditions which might exist in the world we know. The first successful attempts have consisted in the production of organic substances by the action of light on purely inorganic substances.[2] Moore and Webster,[3] in London, have now succeeded in inducing such synthesis of organic matter (aldehyd) in the presence of inorganic colloidal uranic and ferric hydroxids in very dilute solutions, the latter acting as catalysts for light-energy just as does the chlorophyl of the green plant. These inorganic catalysts are not rare, and in the words of the English biochemists, "such a synthesis occurring in nature probably forms the first step in the origin of life."

The process of evolution of simple organic substances thus having been demonstrated in an environment of sunlight and simple inorganic compounds, we can more readily picture the subsequent steps in which derivatives of more complex organic nature would arise from these with additional uptake of energy; but at this point we fancy some one asking, How about the production of the living from the lifeless organic matter? To this we must answer that there is mystery enough in the domain of medicine without attempting for the moment to penetrate into such ultimate secrets.

2. Usher and Priestley: Proc. Roy. Soc. London, 1906, B, lxxvii, 369; lxxviii, 322.

3. Moore, B., and Webster, T. A.: Synthesis by Sunlight in Relationship to the Origin of Life; Synthesis of Formaldehyd from Carbon Dioxid and Water by Inorganic Colloids Acting as Transformers of Light Energy, Proc. Roy. Soc. London, 1913, B, lxxxvii, 163.

Current Comment

THE READY RECKONER FOR THE BUSY DOCTOR

The day has not yet passed when the nostrum and proprietary manufacturer presumes to act as postgraduate instructor to the doctor—especially to the one who is not up in modern medicine. Happily, this kind of postgraduate instruction is not so common as it was eight or ten years ago, before the Council on Pharmacy and Chemistry began its work. The latest advertising scheme of this kind comes from the promoter of a "blood-stimulating" preparation (Hemaboloids, Arseniated [with Strychnia]), and is in the form of a ready reckoner for the diagnosis of pathologic sputum. The thing consists of a revolving arrow surrounded by circles containing illustrations of bacteria such as no human eye ever saw through a microscope. The physician, apparently, is expected to point the arrow to that field which resembles what he sees, or thinks he sees, in the microscope, and then, through a window in the tail of the arrow, observe the name of the organism and the disease which it produces. The device is of no value, of course, to the man who cannot tell one end of a microscope from the other; to the man who does know something, even a little bit, of bacteriology, it will appear either as an insult or a joke; in either case, after spinning the arrow once or twice, he will consign it to the waste-basket. It is hoped that there is no physician to-day so lacking in knowledge as to see any value in such a ready reckoner, so wanting in professional self-respect as to post the badge of the nostrum-promoter on his walls or so servile in spirit as to prescribe the nostrum on the basis of pseudoscientific literature provided by its manufacturer.

THE MARRIAGE LAW IN WISCONSIN

At the last session of the Wisconsin legislature an amendment to the marriage law of the state was adopted, providing that all male persons making application for a license to marry shall within fifteen days prior to such application be examined as to the existence or non-existence of any venereal diseases. It is further required that the certificate of the physician making the examination shall show "that such a person is free from acquired venereal diseases so nearly as can be determined by physical examination and by the application of the recognized clinical and laboratory tests of scientific search." It also provides that physicians making such examinations shall be duly licensed to practice and shall be of a good moral character and scientific attainments and not less than thirty years of age. For the examination and certificate the physician is to be paid a fee by the applicant not to exceed $3. If the applicant

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is indigent, the examination may be made by the county physician without charge. The law further provides that "any physician who shall knowingly and wilfully make any false statements in the certificate . . . shall be guilty of perjury . . . and a conviction under this subsection shall revoke the license of such a physician to practice in this state." Physicians are thus expected to furnish certificates, knowing that any false statement therein will put in jeopardy their right to practice medicine and to earn a professional income in the state. The physicians of the state were active in securing the adoption of this law. It is safe to say that 95 per cent. of the medical profession of Wisconsin are in favor of the principle of the legal restriction of marriage to those who are physically fit to enter into such a contract. Nevertheless, strenuous opposition has arisen against the enforcement of the law among members of the medical profession. The Milwaukee Medical Society has taken a definite stand against it and its members have been quoted as saying that they will refuse to furnish certificates. Unfortunately, the first statement which appeared was simply that physicians objected because the fee of $3 was not satisfactory. Newspapers throughout the state have consequently described the situation as a "strike of physicians" for higher compensation. When the situation is understood it is seen to be entirely different from that presented by this statement. The law requires that physicians making such examinations must apply "recognized clinical and laboratory tests of scientific search." Such an examination would involve not only a physical examination of the applicant but also a microscopic examination for the detection of gonococci and a Wassermann test for syphilis. The making of these examinations requires an elaborate laboratory equipment so expensive that few physicians possess it. The customary fee for a Wassermann test alone is from ten to twenty-five dollars. Even the large commercial laboratories specially equipped for such work and making many such examinations daily charge a fee of $5. Certainly this amount must be recognized as the smallest sum for which such an examination can fairly be made. A conscientious examination for the detection of gonorrhea should also entitle the examiner to an adequate fee. Yet this law provides that physicians shall make both of these examinations as well as a physical examination for $3. This is not only absurd, but also unfair and inequitable. It places on the medical profession the financial burden of enforcing a law made solely for the public good. Physicians are required to furnish certificates and if such certificates are inaccurate, the physician's professional standing is forfeited. It is highly desirable that unfit persons or persons with communicable diseases should be debarred from marriage. Such laws are for the public good and the state should provide for their enforcement at the expense of the entire public and not at the expense of a small portion of it. If the state, for the benefit of society and future generations, sees fit to require an expensive examination as a condition for marriage, then the state should provide the means and the men by which such an examination shall be made.

Medical News

COLORADO

Antityphoid Inoculation of National Guard.—The general order of inoculation of members of the National Guard, now on strike duty in and around Trinidad, to guard against typhoid fever, was put into effect December 5.

County Hospital Appointments.—The advisory board has announced the staff for the Denver City and County Hospital for the year beginning December 1: Drs. James M. Perkins, Aubrey H. Williams and Orville D. Wescott, all of Denver, make up the board and the staff is composed of Denver physicians who give their services to the hospital.

Conference Regarding Denver Insane.—The overcrowded condition of the insane ward in the Denver State and County Hospital and the refusal of the state to accept patients in the state hospital caused a clash and a threatened suit between Denver and the state. The conference between Mayor James M. Perkins and Governor Ammons was followed by a promise of relief for the overcrowded ward.

CONNECTICUT

New Officers.—Bridgeport Medical Society, December 2: president, Dr. J. Murray Johnson; secretary, Dr. George H. Warner.

Hospital News.—A fire in the Hartford Hospital, December 11, necessitated the removal of forty-two patients from one ward. No casualties occurred and the fire was quickly extinguished.——The work on the new Association Service Hospital, New Haven, will begin about February 1.

ILLINOIS

Personal.—Dr. Nelson C. Phillips, Freeport, has been appointed deputy coroner in Stephenson County, vice Dr. H. E. Morrison resigned.——Dr. Walter L. Hogland, Peoria, has been elected physician of Peoria County.

New Officers.—Kankakee County Medical Society at Kankakee, December 11: president, Dr. George H. Lee; secretary, Dr. Charles F. Smith, both of Kankakee.——Morgan County Medical Society at Jacksonville, December 11: president, Dr. Alfred J. Ogram; secretary, Dr. George H. Stacy, both of Jacksonville.——Twin City Peru-La Salle Medical Society at Peru, December 9: president, Dr. Bert E. Fahrney; secretary, Dr. Frederick A. Guthrie, both of La Salle.

IOWA

Work of the State Board.—Dr. Walter L. Bierring, president, and Dr. Guilford H. Sumner, secretary, of the State Board of Health, announce to the people of the state that the plan of work outlined by the board contemplates a sanitary investigation of every city and town line, including inspection of all public water-supplies, sewage-disposal plants and means of garbage disposal.

Reporting of Venereal Diseases.—Under the terms of the "black plague" law passed by the last general assembly, which goes into operation January 1, blanks have been prepared by the State Board of Health to be sent out to the physicians of the state for reports of venereal diseases. According to the law, venereal diseases are declared contagious and infectious and physicians are required to report all cases coming under their notice within twenty-four hours after discovery.

KANSAS

Sanatorium Nearly Ready.—It is announced that the State Tuberculosis Sanatorium, Norton, will be ready to receive patients early in January although the entire building will not be complete until summer.

Hygienic Teacher in Public Schools.—The Atchison Board of Education has voted to employ a teacher of hygiene in the public schools. The teacher will be a trained nurse who will instruct the various teachers of the staff in hygiene and will also make regular periodical examinations of the school children.

New Officers.—Cowley County Medical Society at Arkansas City, December 11: president, Dr. Samuel J. Guy, Winfield; secretary, Dr. Benj. C. Geeslin, Arkansas City.——Allen County Medical Society at Iola, December 10: president, Dr. Omar L. Cox; secretary, Dr. Frederick L. B. Leavell, both of Iola.——Cherokee County Medical Association at Columbus, December 8: president, Dr. Robert M. Markham, Scammon; secretary-treasurer, Dr. Earl L. Parmenter, Mineral.

KENTUCKY

Decision Regarding Dairies.—A very important decision has recently been handed down by the appellate court in an opinion written by Judge Hannah which gives to boards of health power to regulate city dairies. The Covington Board of Health was restrained by the Kenton circuit court from enforcing a stringent regulation of the city dairies, one of which required milk to be transported in sealed, transparent bottles. A dairyman refused to comply with this requirement and secured the injunction. Judge Hannah in his opinion said, "We are not inclined to take the narrow view that the board powers conferred on a local board of health can be exercised only when epidemics actually exist or when the cause of sickness is such as to amount to a nuisance." The opinion further said, "the most effective way to prevent disease is to remove the cause thereof," and if the local board considered this regulation essential to the health of the community, the court would not interfere unless the regulation should appear to be "unreasonable or oppressive." The court said it was neither, and that the powers of local boards of health are not derived from the city council, but from the statutes.

MISSISSIPPI

County Health Officers Meet.—The county health officers of the state held a meeting in Jackson, October 28 and 29, to perfect a permanent organization for mutual benefit and for the advancement of hygiene and sanitation. Of the seventy-seven county health officers of the state, sixty-five were in attendance. Dr. Inman W. Cooper, Newton, was elected delegate to the National Federation of State License Boards.

New Officers.—Lauderdale County Medical Society at Meridian, December 11: president, Dr. T. D. Bordeaux, Meridian; secretary-treasurer, Dr. Gilbert F. Douglass, Chunky.——Newton-Neshoba-Winston Tri-County Medical Society, Newton, December 9: president, Dr. Daniel J. Rush, Philadelphia; secretary-treasurer, Dr. Sidney A. Majure, Dixon.——Hinds-Rankin Medical Association at Jackson, December 9: president, Dr. Robert S. Curry, Jackson (reelected); secretary-treasurer, Dr. James H. Fox, Asylum (reelected).——Hancock County Medical Society organized at Bay St. Louis: president, Dr. Joseph W. Moody, Prentiss; secretary-treasurer, Dr. Alphonse A. Kergosien, Fenton.

MISSOURI

Personal.—Dr. Luther M. Callaway, Kansas City, has succeeded Dr. Eugene Hamilton, resigned, in the school medical inspection service.——Dr. J. B. Freeman, Sturgis, is reported to be critically ill.

Physicians on Duty Day or Night.—The system whereby physicians of the St. Joseph's Welfare Board may be reached at any hour of the day or night was adopted by the board at its meeting, December 8.

Hospital Notes.—The new hospital building being erected in Springfield is to be known as the Southwestern Missouri Hospital. The association is incorporated for $20,000 and the board of directors is made up as follows: Archibald A. Low, president; Dr. Thomas O. Klingner, vice-president; Dr. David U. Sherman, secretary and treasurer and Dr. Moses C. Stone Wellesley and George D. McDaniel.——The Sisters of the Immaculate Conception of Marysville have purchased a tract of land in Hannibal upon which a hospital will be erected at a cost of $30,000.

New Officers.—Polk County Medical Society at Morrisville, December 13: president, Dr. R. Lee Russell, Humansville; secretary, Dr. J. F. Roberts, Bolivar (reelected).——Green County Medical Society at Springfield, December 12: president, Dr. George B. Lemmon; secretary, Dr. Thomas O. Klingner, both of Springfield.——Marion County Medical Society at Hannibal, December 5: president, Dr. Isaac E. Hill; secretary-treasurer, Dr. John J. Farrell.—Audrain County Medical Society at Mexico, December 3: president; Dr. Fred Griffin; secretary-treasurer, Dr. Harry W. Gibbs.——St. Joseph-Buchanan-Andrew County Medical Society at St. Joseph, December 3: president, Dr. Joseph J. Bansbach; secretary, Dr. William F. Goetze.——Grundy County Medical Society at Trenton, December 3: president, Dr. John M. Stone, Laredo; secretary, Dr. Ola B. Rooks, Nevada.——Jackson County Medical Society at Kansas City, December 2: president, Dr. Richard L. Sutton; secretary and editor of the bulletin, Dr. H. Lewis Hess, both of Kansas City.——Pike County Medical Society at Elsberry, December 1: president, Dr. Ezekiel M. Bartlett, Clarksville; secretary, Dr. Forrest V. Keeling, Elsberry.

St. Louis

Massachusetts Society Gets Medical Library.—The medical library bequest to Dr. John Green by his uncle of the same name has been devised to the Worcester (Mass.) District Medical Society in memory of his uncle.

Dispensary to be Closed.—The hospital board has announced that the City Dispensary, Branch Number 3, will be closed January 1, and that the physicians and attendants will be transferred to the Central Dispensary where there is more need for their services.

Personal.—Dr. C. W. Bassett has resigned as assistant police surgeon.——Dr. Robert E. Graul is reported to have been awarded a verdict of $6,000 damages against the United Railroad Company for injuries received in a street-car accident, March 12.——Frank E. Chapman has succeeded Dr. Wayne Smith as superintendent of the City Hospital.——Dr. Christian H. Diehl has purchased the farm on which the Shannon County Cave is located.

NEW YORK

New Officers.—Dunkirk and Fredonia Medical Society at Dunkirk, December 10: president, Dr. Walter H. Vosburg; secretary-treasurer, Dr. William J. Sullivan, both of Dunkirk.——Medical Society of the County of Rensselaer at Troy, December 9: president, Dr. Hermon C. Gordinier; secretary, Dr. John J. McShane, both of Troy.——Wayne County Medical Association at Lyons, December 9: president, Dr. Ethan A. Nevin, Newkirk; secretary-treasurer, Dr. Major A. Vedder, Lyons.——Wellsville Medical Club, organized December 10: president, Dr. Francis E. Comstock; secretary-treasurer, Dr. R. M. Eaton.——Onondaga County Medical Society at Syracuse, December 9: president, Dr. I. Harris Levy; secretary, Dr. Henry B. Doust, both of Syracuse.——Rockland County Medical Society at Haverstraw, December 3: president, Dr. J. William Giles, Nyack; secretary, Dr. Ralph De Baun, Congers.

Alienists Urge New Crime Law.—The committee of the Bar Association on the commitment and discharge of the criminal insane, which was appointed last January, has sent to the justices of the supreme court and to the district attorneys throughout the state opinions of alienists on the advisability of a change in the laws affecting the verdicts of insanity and criminal trials. The proposed change is intended to enable juries where a defense of insanity is made to render a verdict of "guilty, but insane," rather than the present "not guilty on the ground of insanity." The plan under the new verdict is to have the defendant sentenced to a state asylum for the criminal insane "until such time as in the opinion of the governor on an application for pardon he may be set free with safety to the community." The committee states that the proposed amendment has been in operation in England for thirty years and seems to have worked well. Opinions on this proposed change have been expressed by Dr. Orville J. Wilsey of the Long Island Home at Amityville; Dr. James V. May, Albany, of the State Hospital Commission; Dr. Arthur W. Hurd, superintendent of the Buffalo State Hospital; Dr. Austin Flint and Dr. Allen McLane Hamilton of New York.

New York City

Preventorium Report.—At the annual meeting of the Tuberculosis Preventorium for Children, December 5, Mr. Marcus M. Marks, president-elect of the borough of Manhattan, resigned. He announced that the institution which is located at Farmingdale, N. J., was running with smoothness and efficiency and there was a balance of $19,988 in the treasury, of which $3,000 is to be used to complete the first half of a new school building. Dr. Herman M. Biggs was elected president of the institution.

American Museum of Safety Awards Medals.—The annual meeting of the American Museum of Safety was held December 12. The Travelers' Insurance Medal went to the New York Telegraph Company because of the steps it had taken to protect employees, chiefly the women workers. The Louis Livingston Seaman medal, awarded for progress and achievement in the promotion of hygiene and the mitgation of occupational diseases went to the United States Steel Corporation. The General Electric Company of Schenectady received the Rathenau medal for the best device or process in the electrical industry for protecting life and health.

Extension of the Pasteurization Provision of the New York Milk Ordinance.—The Board of Health of New York has amended the sanitary code and rules and regulations for the sale of milk, requiring the pasteurization of Grade B milk which was formerly permitted to be sold for certain purposes without pasteurization. This extends the requirements of pasteurization to all milk now used in the city except certified milk and similar special grades. This action followed the study of an epidemic of typhoid fever in the city which was traced to Grade B milk sold in restaurants under the

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provisions of the ordinance which allowed such milk to be sold raw for drinking purposes only when so labeled.

Medical Charity Faces Deficit.—The Hospital Saturday and Sunday Association in its annual report issued December 1 states that during the fiscal year which is closed, the expense of maintenance of its forty-seven hospitals was $4,952,309, an increase of $382,441 over the year before. The receipts of the hospitals during the same period were from income $2,160,957 and from endowment $1,023,159, leaving $1,749,193 to be raised by voluntary contributions. The income of these hospitals for the last year was $18,706 less in payments from patients, $25,657 less in payments from the city for public charges and $21,890 less from endowment as compared with the year before. During the year a staff of 2,047 nurses in addition to hundreds of physicians took care of 105,669 bed patients, while in the dispensary 507,277 cases were treated with a total of 1,673,679 visits.

Clean Milk Bottle Ordinance Sustained.—The provision of the sanitary code of the city of New York which makes it a misdemeanor "to receive or have in possession" any receptacle used in the transportation or delivery of milk or cream which has not been washed immediately after emptying, has been sustained by the highest court of the state of New York. It has been construed as violating no constitutional right and is within the police power of the state. The duty of cleansing the receptacle is cast first on the person who empties it. If he fails to perform this duty then it extends to any person into whose possession it falls. Certain drivers of a milk company had left unwashed milk cans on the platform of a railway station and the company was prosecuted for violation of the ordinance. The case was first tried in the Court of Special Sessions and the defendant was found guilty. In two appeals to the higher courts the judgment was affirmed.

PENNSYLVANIA

Recent State Board Regulation.—Under the authority given the state board by the act of assembly, approved April 27, 1905, rules and regulations have been promulgated by the board forbidding the use of common drinking cups unless boiled or disinfected after each use, forbidding the use of common towels, forbidding the use of a common brush by barbers unless disinfected after each use and providing that eating and drinking utensils in public eating places shall be thoroughly cleansed after each individual use. Impetigo contagiosa and scabies have been made reportable diseases, as has also ophthalmia neonatorum, by a separate act, approved June 5, 1913.

Philadelphia

To Unite City Hospitals for Efficiency.—Representatives of fifty-five hospitals met in the office of Chief Vogelson, City Hall, on December 11, to plan the adoption of an efficiency program for the hospitals and dispensaries of the city. A $7,000 fund is to be raised for the purpose of making an "efficiency" study of the whole hospital situation. According to Mr. F. W. Leporin, an efficiency engineer of New York, the fifty-five hospitals of Philadelphia cost each year for maintenance about four million dollars, and he estimated that the efficiency plan would save these institutions about two hundred thousand dollars a year. To bring this about, which means eliminating duplication of hospital work, an efficiency engineer would be employed to outline and chart the proper organization and management of the Central Record Bureau with subdivisions covering general efficiency departments, accounting bureaus, office methodizing departments, purchase, testing, and employment bureaus. The result of his work would be the organization of a general efficiency commission which would cooperate with the several hospital efficiency committees. Dr. Joseph S. Neff, director of Public Health and Charities, presided.

WASHINGTON

State Board Election.—The State Board of Medical Examiners at its meeting in North Yakima, November 30, elected the following officers: president, Dr. R. P. Smith, Seattle; vice-president, Dr. J. L. Walker, Sunnyside; secretary, Dr. Conrad N. Suttner, Walla Walla, and treasurer, Dr. A. L. Nelson, Spokane.

WEST VIRGINIA

Personal.—Dr. E. W. Strickler, Fairmont, has recovered and resumed practice.——Dr. A. U. Weinberger, Wheeling, has been appointed a member of the staff of the Ohio Valley Anti-Tuberculosis League Dispensary.

Health Officers Convene.—The first meeting of the State and County Health Officers of West Virginia with the State Board of Health was held in Parkersburg, November 28. During the earlier part of the day a school of instruction was held and in the evening there was a general meeting at which the president and secretary of the board and others delivered addresses. The next school of instruction is to be held in Charleston in April, chiefly for the benefit of the health officers from the southern tier of counties in the state.

State Hygiene Laboratory Established.—At a conference between the governor and the West Virginia State Board of Health, it was decided to establish a hygienic laboratory in connection with the School of Medicine of the University of West Virginia, Morgantown. An appropriation was set aside for equipment and for salaries of the necessary laboratory men. An important feature of the laboratory will be the study and prevention of contagious diseases. Examinations will be made free of charge for physicians and health officers in case of suspected tuberculosis, diphtheria, typhoid fever, gonorrhea, anthrax, trichinosis, etc. Chemical and bacteriologic examinations of water and milk will also be made. Vaccines will be prepared and research work and classes in public health will be conducted. The officers of the board are: president, Dr. William W. Golden, Elkins; secretary, Dr. Samuel L. Jepson, Wheeling; director, Dr. John N. Simpson, Morgantown; chief pathologist and bacteriologist, Dr. Aaron Arkin; chief chemist, Dr. A. L. Whitehill, and pharmacist, Dr. W. H. Schultz.

WISCONSIN

Health Budget Cut.—The Milwaukee Board of Estimates, after making a cut of $50,000 in the health department estimate for 1914, has still recommended the appropriation of $29,000 more than was asked for in 1913.

Would Separate Inebriates, Epileptics, Idiots and Insane.—In the biennial report of Dr. Charles Gorst, superintendent of the Mendota State Hospital for the Insane, he recommends the establishmen: of state homes for inebriates and a state colony for epileptics, and, furthermore, that idiots and inebriates should be confined in county institutions.

Sanatorium News.—By a vote of twenty to twelve, the Board of Supervisors of Sheboygan County decided against the appropriation of $25,000 for a county tuberculosis sanatorium. ——The Racine County board has appropriated $12,000 a year for the support of its sanatorium known as Sunnyrest.—— The Tuberculosis Sanatorium for Outagamie County was recently opened. The institution is on the river bank near Kaukauna and has accommodations for twenty-four patients with sun parlors and other requisites.

Eugenic Marriage Law Makes Trouble.—The marriage law which goes into effect January 1 provides that male applicants for marriage licenses be required to show health certificates showing them to be physically fit for matrimony. The law also stipulates a fee of three dollars for the necessary certificate. As this certificate includes a Wassermann test, which in itself commands a fee of from five to ten dollars, physicians are making earnest protests and many say that they will refuse to make the examinations and issue the certificates required under the law.

Medical Aid for Traction System.—The Milwaukee Electric Railroad and Light Company has arranged for the benefit of its employees to reorganize its medical service. Under this rearrangement, Dr. Charles H. Lemon will have charge of the central district, with headquarters in the Public Service Building; Dr. E. W. Miller will be in charge of the southern district with headquarters at the National and Kinnickinnic stations, and Dr. W. H. Owens will be in charge of the northern district with headquarters at the Farwell and Fond du Lac stations. Under this arrangement it will be possible for the employees who need medical aid to reach the physician far more promptly than under the old system.

New Officers.—Milwaukee County Medical Society, December 13: president, Dr. Dennis J. Hayes; secretary, Dr. Daniel Hopkinson, both of Milwaukee. The society, by vote, has refused to make the examination required by the new hygienic marriage law.——Kenosha County Medical Society at Kenosha, December 10: president, Dr. Curtis H. Gephart; secretary-treasurer, Dr. Albert J. Randall, both of Kenosha.——Dane County Medical Society at Madison, December 9: president, Dr. Thomas W. Tormey; secretary, Dr. Frank S. Meade, both of Madison.——Waukesha County Medical Society at Oconomowoc, December 5: president, Dr. Walter S. Wing, Oconomowoc; secretary-treasurer, Dr. S. Breck Ackley, Waukesha.——Racine Physicians' Business Association, December 4: president, Dr. Walter S. Haven; secretary, Dr. George W. Nott.——Wood County Medical Society at Marshfield, December 3: president,

Dr. Victor A. Mason; secretary-treasurer, Dr. James B. Vedder, both of Marshfield.

GENERAL

Otologists to Meet at Atlantic City.—Dr. John B. Ray, secretary of the American Otological Society, announces that the annual meeting of the organization will be held at the Hotel Chelsea, Atlantic City, N. J., May 27 and 28, 1914.

Medical and Surgical Exhibit at Panama Exposition.—Among the medical exhibits at the Panama Exposition in San Francisco will be a complete demonstration of the methods employed under the directorship of Col. W. C. Gorgas in the sanitation of the Canal Zone during the construction of the Panama Canal. This should prove a valuable educational feature to the physicians and sanitarians as well as to the public visiting the exposition.

Tri-State Meeting.—The tenth annual meeting of the Tri-State Medical Society of Arkansas, Louisiana and Texas was held in Texarkana, December 10, and the following officers were elected: president, Dr. Preston Hunt, Texarkana; vice-presidents, Drs. Joseph P. Runyan, Little Rock, Ark.; Thomas B. Allison, Redwater, Tex., and Joseph E. Knighton, Shreveport, La.; and secretary, Dr. Jacob M. Bodenheimer, Shreveport (reelected for the sixth term).

American Medical Men of Vienna Meet.—On November 26, the American Medical Association of Vienna celebrated Thanksgiving Day by a banquet at which Professors Lorenz, Alexander Fuchs and Politzer were the speakers representing the University of Vienna. Dr. John W. Summers, Walla Walla, Wash., presided as toastmaster. About one hundred and fifty American physicians with their wives were present, and in addition many of the American colony of Vienna.

Ambassador Entertains.—The American Ambassador and Mrs. Penfield gave a Thanksgiving Day banquet to Americans residing at present in Vienna. The American Medical Association of Vienna was represented at this dinner by its president, Dr. H. T. Tangeman, Cincinnati; Vice-President and Mrs. J. W. Summers, Walla Walla, Wash.; Capt. M. A. Delaney, U. S. Army, military attaché; the secretary, Dr. J. M. Myers, Chicago, and the treasurer, Dr. John J. Sullivan, Lawrence, Mass.

Bequests and Donations.—The following bequests and donations have recently been announced:

Medical Department of the University of Cincinnati, a bequest of $25,000 to the chair of medicine by the will of Mrs. Jeannette Moss.

Bethesda Hospital, Cincinnati, Maternity Ward, a donation of $2,000 from "an Illinois friend."

Dr. Melvin G. Overlock, Worcester, Mass., as trustee, the income of $25,000 for the anti-tuberculosis fight in Worcester and vicinity by the will of Persis G. Boynton, Worcester.

Children's Hospital, Philadelphia, $60,000, and Germantown Hospital $5,000, by the will of Mary H. Russell.

Jewish Charitable and Educational Union, St. Louis, an increased donation of $7,000 by the directors.

Philadelphia Home for Incurables, a donation of $7,500 to maintain a free bed in the cancer annex of the institution, by George W. Nevil.

VIENNA LETTER

(From Our Regular Correspondent)

VIENNA, Dec. 1, 1913.

Health Statistics

An interesting report on the number of cases of infectious diseases has been published recently in connection with the new public health act. This law stipulates the payment of a sum of 50,000 kronen ($10,000) by the government to the "union of Austrian medical councils" for the purposes of old-age pensions, orphans' grants, and the like, being a recognition of the unpaid services rendered by the medical profession to the general health. It is, as it were, an equivalent to the fees for notification of infectious diseases paid in some countries. In order to divide up this sum in proportion to the services rendered, it was decided to ascertain the number of reports of such cases in the different districts. Thus, in 1910, the number of practitioners in Vienna amounted to 2,382 men. The average number of notifications of infectious cases within the last ten years made by them was 32,265; the population in 1910 was 2,004,939. In Bohemia there were 2,670 doctors, who reported 103,236 cases; the population was 6,730,000. In Tyrol, with nearly a million inhabitants, the 571 doctors reported 15,820 cases. In the whole of Austria, with a population of over 28,000,000 and 10,498 doctors, the yearly average of notifications was 421,000, or less than 2 per cent. It is interesting to note that the proportion of infectious diseases to the population is fairly constant in all districts and does not vary much all over the empire; but the work done by the doctors is much heavier in districts in which the relative frequency of infectious diseases is low (rural or mountainous districts). These districts will get a larger share of the above-mentioned sum.

A Strike of Medical Students

The medical students in Vienna have resolved to organize a strike as a sign of their dissatisfaction with the present system of examination. Up to a short time ago the students need not fail in their studies, even if they did not pass the examinations. They were allowed to repeat the examination within from three to six months and they could also choose the year or half-year in which they wanted to be examined. Now they are obliged, by the new regulations, to pass the severe examinations in a short time within each other—most within six weeks—and if a student has permitted more than a year to lapse between his first examination (on biology and anatomy) and his last one (on gynecology and ophthalmology), he has to repeat the first-named two subjects. Also, those students who have to serve with the army are now worse off than before in several respects. The regulations come into force just now, and the students in the fourth and fifth years who have hitherto been studying on the old system, are chiefly affected by them. They tried all means to avert the difficulties but as all endeavors were useless, they organized a strike in which all students supported them. The ministry of education will have to do away with at least the worst grievances, otherwise a general prolonged standstill of the teaching may be expected.

Infant Mortality and Stillbirths in Austria

The official figures dealing with the mortality of infants in this country show with an interesting and instructive exactness the beneficial influence of prolonged wet-nursing on the expectation of the life of children. In those districts in which it is the custom to give the babies the mother's breast, there died out of every hundred infants born alive, between 16 and 17 within the first year of life, while the figure for infants living only one month or under was between 6 and 7. In other districts where breast-feeding is soon stopped (from 1 to 5 months) the number of infants dying within twelve months was from 18 to 23, while the number of those dying in the first month of life was about the same as in other districts (from 6 to 8). The effect of mother's milk is thus clearly illustrated. The figures for the whole of Austria are 20.5 dying within the first year and 7.9 within the first month of life. All these figures are an average for the last five years. It is also significant that in districts with old customs, stillbirths were rather few. Out of a thousand births, from 9 to 15 were stillbirths, while in districts in which there are industries or where modern life has caused change of habits, the figure was from 20 up to 41 per thousand. For Austria as a whole the figure stands at 25.2. Poverty affects the death-rate only when the wife (or mother) has to earn a wage besides doing her housework, while it loses its otherwise deleterious influence on the offspring, at least for the first part of life when the mother can nurse her baby with its natural, not with artificial, food. Anyhow there is noticeable a constant decrease of the fertility of our population. Families with more than five living children under 10 years are becoming rare now. In the "large" families the youngest children are at present more than 15 years old. It is due to the difficulties of modern life which in this country have existed since about the year 1900.

The Fight between Krankenkassen and Doctors

The conflict between the sick-clubs and their physicians has lasted now over a year and it seems that the latter will carry their own and win. As the "clubs" are bound, by law, to procure medical help for their members or to give them an equivalent for it in cash, the member paying the doctor himself, they selected the latter method, not finding enough doctors willing to work on the old terms. The clubs have discovered that the payment of the members cost them much more than they spent formerly on doctors, and such an argument on the pocket is most convincing. The doctors, however, have found out, too, that the clubs have to come to terms and now it is quite sure that their services will have to be paid for at a more remunerative scale. The principal difference now between the clubs and the doctors is the demand, by the latter, that the "black-leg" practitioners—those who have accepted appointments pronounced boycotted—should be dismissed. The clubs refuse, being bound by contracts, but the organization of the profession must keep up this demand, for future conflicts. It is quite certain that an understanding will be arrived at in a short time.

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Marriages

WILLIAM LONG, M.D., St. Paul, Minn., to Miss Mary Vail Tisdale of Slayton, Minn., at Minneapolis, December 10.

LOUIE ETHLYN VANDERVOORT, M.D., to Mr. Henry Martin Stegman, both of Battle Creek, Mich., November 25.

THOMAS P. FORE, M.D., Brookfield, Mo., to Miss Bess Griffith of Grand Island, Neb., at Kansas City, December 8.

THOMAS JOHN MURRAY, New London, Conn., to Miss Helen G. O'Rourke of Waterbury, Conn., November 18.

BEDFORD E. LOVE, M.D., Roxboro, N. C., to Miss Julia Louise Cole of Danville, Va., at Roxboro, December 3.

JOHN EDWARD CLARK, M.D., Streator, Ill., to Miss Evelyn Meyer Brogley of Butte, Mont., December 3.

CLARENCE A. PEASLEE, M.D., to Miss Frances D. Hobson, both of Bath, Me., in Portland, December 9.

ESICK ALBERT AISENSTAEDT, M.D., Chicago, to Miss Ethel Ferrell of Nashville, N. C., December 9.

DAVID EARLE LOWE, M.D., New Salem, Pa., to Miss Ella Brooke of Uniontown, Pa., December 12.

ROY FREDERICK BREEDEN, M.D., to Miss Marjorie Jane Marne, both of Chicago, December 9.

HERMAN C. TIETZE, M.D., to Miss Maude O. Buxton, both of West Salem, Ill., October 29.

Deaths

John Giles Cecil, M.D. Hospital College of Medicine, Louisville, 1879; one of the best known practitioners of Louisville; died at his home, December 12, from heart disease, aged 58. He was born in Monticello, Ky., the son of a wealthy planter and banker, and received his academic training at Princeton University from which he was graduated in 1876. After a service as intern in the Louisville City Hospital and an extensive postgraduate course abroad, he began practice in Louisville. Dr. Cecil was a Fellow of the American Medical Association, president of the Kentucky State Medical Association in 1907, professor of medicine in the University of Louisville and since the merger of the medical school, a member of the executive committee of the faculty and trustees. He was also medical director of the Inter-Southern Life Insurance Company and for three years had been president of the Louisville branch of the Young Men's Christian Association.

Orlando P. S. Plummer, M.D. Jefferson Medical College, Philadelphia, 1857; a member of the Oregon State Medical Association and one of the first telegraphers to take messages by sound; a surgeon of volunteers and army telegrapher during the Civil War; for nearly fifty years a resident of Portland, Ore.; for several years superintendent of the Pacific division of the Western Union Telegraph Company; one of the first members of the faculty and first dean of the Medical Department of Willamette University, Salem; a member of the first state board of medical examiners; for two terms a member of the state legislature and twice member of the city council of Portland; died at his home in Hillsdale, Ore., December 7, aged 77.

Abiel Ward Nelson, M.D. Harvard Medical School, 1861; surgeon of the Eighty-Eighth Massachusetts Volunteer Infantry during the Civil War; a member of the Connecticut State Medical Society; surgeon-general of the National Society of Mayflower Descendants; one of the organizers of the New London City and County medical societies; trustee of the Manwaring Memorial Hospital; died at his home in New London, December 6, aged 77.

Rollin Clayton Ward, M.D. Harvard Medical School, 1870; a member of the American Medical Association; a veteran of the Civil War; formerly a practitioner of Northfield and Shoreham, Mass., and East Orange and Princeton, N. J.; died at the home of his niece in St. Johnsbury, Vt., December 9, aged 75.

Caleb M. Lowder, M.D. Medical College of Indiana, Indianapolis, 1881; a member of the Indiana State Medical Association; died at his home in Dugger, Ind., December 10, from heart disease, aged 55.

John Walter Staples, M.D. University of Vermont, Burlington, 1880; a Fellow of the American Medical Association and once president of the New Hampshire Medical Society; a trustee of Proctor Academy, Andover, and secretary of the Daniel Webster Birthplace Association; died suddenly in his private hospital, Sanborn Hall, Franklin, N. H., December 11, from cerebral hemorrhage, aged 58.

Zaccus Prall Boyer, M.D., Jr. University of Pennsylvania, Philadelphia, 1881; aged 57; formerly chief surgeon for the Philadelphia and Reading Railroad and located at Pottsville, Pa.; for the last nine months a practitioner of Philadelphia; fell while descending a stairway from his office, December 6, fracturing his skull, and died before he could be taken to a hospital.

Albert Blodgett Weymouth, M.D. Bellevue Hospital Medical College, 1863; for many years a medical missionary of the Protestant Episcopal Church at Lahaina, Maui, Hawaii; honorary canon of St. Andrews Cathedral, Honolulu; a Fellow of the Royal Horticultural Society; died at his post in Lahaina about October 27, aged 74.

William Mackall Wheeler, M.D. University of Virginia, Charlottesville, 1895; Surgeon and Lieutenant Commander, U. S. N. with station at the Marine Barracks, Norfolk Navy Yard; a Fellow of the American Medical Association; died in the U. S. Naval Hospital, Washington, D. C., December 14, aged 39.

J. T. Parker, M.D. Medical College of South Carolina, Charleston, 1861; a Confederate veteran; formerly of Buena Vista, Miss., but since 1895 a resident of Waco, Tex.; died at the home of his daughter in the latter city, November 27, from cerebral hemorrhage, aged 76.

Charles Stuart Murray, M.D. Trinity Medical College, Toronto, 1873; L.R.C.S. Edinburgh, 1877; for seven years surgeon on transatlantic steamers and then for a short time a practitioner of Toronto; died at his home in that city, November 6, from pneumonia, aged 63.

William Lewis Judkins, M.D. University of Pennsylvania, Philadelphia, 1894; of Barnesville, O.; a member of the Ohio State Medical Association; died in Mt. Carmel Hospital, Columbus, O., from shock following an operation for ethmoiditis and meningitis, December 9, aged 45.

Sherman Van Ness, M.D. College of Physicians and Surgeons, New York City, 1883; of Chatham Center, N. Y.; in 1889 coroner of Columbia County; died in St. Peter's Hospital, Albany, N. Y., December 2, a week after an operation for appendicitis, aged 54.

John H. Engles (license, Oklahoma, 1908); said to have been a practitioner for forty-one years; died at his office in Newkirk, December 9, from the effects of a gunshot wound to the head, self-inflicted, it is believed, with suicidal intent, aged 66.

Lyman Hall, M.D. Drake University, Des Moines, Iowa, 1902; a member of the Iowa State Medical Society and for eighteen years a practitioner of Spring Hill, Iowa; died in Albuquerque, N. Mex., December 6, from cerebral hemorrhage, aged 44.

Leonora Fletcher Lathe, M.D. New England Female Medical College, Boston, 1886; for fifteen years assistant supreme medical examiner of an insurance fraternity; died at her home in Cambridge, Mass., December 5, from heart disease, aged 79.

Irenaeus J. Atwood, M.D. Rush Medical College, 1889; for twenty-seven years a medical missionary in Fen Chofu, Shansi, China; died in a sanatorium in Puyallup, Wash., October 1, from cerebral hemorrhage, aged 62.

Jacob Walter Eleeza Karr Davis, M.D. University of Buffalo, 1887; a practitioner of Omaha for twenty-six years; died suddenly in a street car in that city, December 4, from heart disease, aged 64.

Norman Eugene Farewell, M.D. Trinity Medical College, Toronto, 1897; assistant surgeon to the Brooklyn Eye and Ear Hospital; died at his home in Brooklyn, December 12, from pneumonia, aged 37.

Thomas Marshall Huntington, M.D. Bellevue Hospital Medical College, 1883; of Amesbury, Mass., was struck and killed by a freight train in the Newburyport station, December 9.

James Franklin Leslie, M.D. Eclectic Medical Institute, Cincinnati, 1900; of Waterville, Wash.; was killed in an automobile accident near that place, November 23, aged 42.

Fitzwilliam Sargent Worcester, M.D. Harvard Medical School, 1873; of Peabody, Mass.; died at the Joshua B. Thomas Hospital in that city, December 7, aged 62.

Benjamin T. Gadd, M.D. Eclectic Medical Institute, Cincinnati, 1865; of Mitchellville, Iowa; died at the home of his daughter in Colfax, Iowa, December 9, aged 76.

William H. Ward (license, California, 1894) a practitioner for fifty years; formerly of Des Moines, Iowa; died at his home in Long Beach, Cal., about December 10.

James S. Morton, M.D. University of Louisville, Ky., 1850; a Confederate veteran; died at his home in Hartford, Ky., December 8, from senile debility, aged 85.

James Vincent Canavan, M.D. Rush Medical College, 1894; a Fellow of the American Medical Association and first mayor of Appleton, Wis., died December 4, aged 53.

Lee O. Rogers (license, Iowa, years of practice, 1887); for thirty-five years a practitioner of Newton; died at his home, December 4, from heart disease, aged 69.

Stanley L. Thorpe, M.D. Cleveland University of Medicine and Surgery, 1882; formerly of Cleveland; died in Salt Lake City, December 7, from uremia, aged 62.

Samuel E. Crose, M.D. Central College of Physicians and Surgeons, Indianapolis, 1888; died at his home in Indianapolis, October 27, from pneumonia, aged 47.

John Houston, M.D. Manitoba Medical College, Winnipeg, 1906; of Cypress River, Man.; died at the home of his father in Starbuck, Man., recently, aged 35.

Ham Hunter, M.D. Ohio Medical University, Columbus, 1893; was found dead in his office in Columbus, November 30, from heart disease, aged 50.

William Thurston, M.D. American Medical College, Eclectic, St. Louis, 1880; died at his home in Orland, Cal., about November 26, aged 92.

James R. L. Daly, M.D. University and Bellevue Hospital Medical College, 1899; died at his home in New York City, November 29, aged 38.

Samuel H. Backus, M.D. Tulane University, New Orleans, 1897; of Pollack, La.; died suddenly at Gueyzan, La., about December 8, aged 40.

Dugald Stewart (license, Ontario, 1876); for more than thirty years a practitioner of Teeswater; died at his home, August 22, aged 64.

William Bertram Arnold, M.D. Eclectic Medical Institute, Cincinnati, 1879; died at his home in Rockford, Ill., November 23, aged 72.

Dorsey L. Morris, M.D. Medical College of Virginia, Richmond, 1897; died at his home in Greensboro, N. C., about November 5.

John Lemuel Bethune, M.D. Halifax (N. S.) Medical College, 1875; died at his home in Baddeck, N. S., September 27, aged 63.

Edward C. Kalmerton, M.D. Rush Medical College, 1887; died at his home in Milwaukee, October 26, from diabetes, aged 59.

Archelaus M. Winn, M.D. Atlanta (Ga.) Medical College, 1867; died at his home in Lawrenceville, Ga., October 25, aged 68.

Charles A. Usilton, M.D. Jefferson Medical College, 1882; died at his home in Philadelphia, December 3, from nephritis, aged 59.

Nathan L. Hammer, M.D. Physio-Medical College of Indiana, Indianapolis, 1882; died at his home in Indianapolis, October 27.

Charles H. Sherman, M.D. Louisville, (Ky.) Medical College, 1889; died at his home in Louisville, December 9, aged 69.

William White Brewer (license, Mississippi, 1882); died at his home in Lamar, September 23, from uremia, aged 85.

Ernest Warren (license, Oregon, 1891); of Newport, Ore.; was found dead in Portland, Ore., October 25, aged 50.

Harvey J. Philpot (license, British Columbia, 1894); died at his home in Vancouver, November 11, aged 80.

Rev. John Gethin Thomas (license, Ohio, 1897); died at his home in Lima, November 15, aged 71.

Marion H. Jackson (license, Arkansas, 1903); died at his home in Neely, November 7, aged 36.

Arthur Fisher, L.R.C.S. Edinburgh, 1880; died at his home in Montreal, December 3, aged 98.

Correspondence

Improved Technic for Blood-Counts

To the Editor:—I desire to make a few comments regarding the clinical report of Dr. Allan Eustis on an "Improved Technic for Blood-Counts: Rapid Method for Securing Exact Amount of Suspension" (The Journal, Nov. 29, 1913, p. 1984).

Although I have not seen the technic of placing the cover-glass on the counting-chamber, as recommended by Dr. Eustis, described in any book or journal before, yet it was the method in vogue at the William Pepper Laboratory of Hygiene at the University of Pennsylvania fourteen years ago.

Incidentally, I would mention the following modification of the *modus operandi* as advised in the article above referred to. The cover-glass is placed on the edge of the counting-chamber, with its edge approximately parallel with the edge of the counting-chamber. Then the tips of the forefingers are placed on the distal side of the cover-glass and the ends of the thumbs on the proximal edge of the cover-glass. While downward pressure is exerted with the forefingers, the thumbs are used to push the cover-glass across the counting-chamber. This technic is advocated, obviously, to cause all of the supposedly contact portion of the cover-glass to be closely in contact with the counting-chamber, while the two thumbs can readily push the cover-glass across the counting-chamber even though the cover-glass is in close contact.

The real object of this communication, however, is to correct one little (but important) point mentioned by Dr. Eustis, namely, regarding the size of the drop. I fear that beginners may find a pitfall in using a large drop of the blood and diluting fluid. Theoretically it would appear that the size of the drop would make no difference; but my experience has been that the smaller the drop (provided there is enough) the more easy it will be to obtain a satisfactory "mount" and the more likely it will be that we shall see Newton's rings after the first trial.

Charles Rea, M.D., York, Pa.

[The preceding letter was referred to Dr. Eustis, who replied that he did not know of the method being used in other schools and that he was positive that no one else in his section of the country had used it for the last eight years. We have also subsequently received the following letters:]

To the Editor:—In The Journal, Nov. 29, 1913, Dr. Allan Eustis of New Orleans gives an improved technic for blood-counts. I remember very clearly that when I was a resident physician at the Medico-Chirurgical College, Dr. J. Donald Zulick, our chief resident physician, showed me the very same technic, so that it is not original with Dr. Eustis. Nevertheless, it is a very good method and saves a lot of time.

C. H. J. Barnett, M.D., Philadelphia.

To the Editor:—In The Journal, Nov. 29, 1913, p. 1984, Dr. Allan Eustis of New Orleans gives an improved technic for blood-counts. This improvement was taught at Jefferson Medical College in 1904, and has been used constantly by most blood workers.

W. H. Kraemer, M.D., Wilmington, Del.

Mizer Sanatorium

To the Editor:—Some time ago those in charge of the Mizer Sanatorium of this place stated to us that they wished to place the institution on a high plane and to conduct it in a strictly ethical manner. To such a degree would they conform to ethical rules that the most particular in matters of this kind would find no room to complain. With this distinct agreement on their part they were allowed to use our names as references.

Of late we have learned that even the ordinary rules of propriety have been violated by them and that these acts of unfairness to us had been going on for some time

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before we learned of their breach of faith with us. We at once notified them no longer to use our names in any of their advertising matter or on their stationery. It appears that before we had learned of the advantage that was being taken of our confidence, others had taken note of their unethical practices.

What we wish to do is to set ourselves right before the medical fraternity and to announce that we do not stand, and have not stood, for anything which we believe or know to be fraudulent or misleading.

EDMUND C. CARR, M.D., JESSE MCCLAIN, M.D., Coshocton, Ohio.

Deaths from Eating Chestnuts

To the Editor:—In THE JOURNAL, Nov. 29, 1913, p. 2001, S. T. A. refers to the newspaper report of the death of a woman from poisoning by eating chestnuts, and asks for an explanation as to how chestnuts can be poisonous.

Aside from your answer that the matter was under investigation by the Bureau of Plant Industry, is it not possible that this patient was a subject of diabetes and that she died from coma from overindulgence in this article of diet? In the dietary for diabetes all forms of nuts are allowed *except* chestnuts, and I have strictly forbidden them to patients suffering from this disease, although diabetic patients have an inordinate craving for chestnuts at this season of the year.

GEORGE J. LOCHBOEHLER, Washington, D. C.

A Note on the Use of Ninhydrin as a Test for Peptone, etc.

To the Editor:—Ninhydrin works best in a strictly neutral medium. Slight acidity or alkalinity destroys its delicacy. Fluids should be made neutral before testing, litmus being used as an indicator.

S. L. CHERRY, M.D., Clarksburg, W. Va.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

REFERENCES TO RECENT ARTICLES ON ARTIFICIAL PNEUMOTHORAX

To the Editor:—Have you any later reports on tuberculous patients treated with intrapleural injections of nitrogen than the one by A. F. Lemke, THE JOURNAL, Oct. 14, 21 and 28, 1899, pp. 959, 1023 and 1077), and afterward printed in pamphlet form? I am much interested in this method and would be glad to have any information you may have on the subject.

C. W. JACKSON, M.D., Albuquerque, N. Mex.

ANSWER.—The following is a list of recent articles on this subject:

Robinson, Samuel, and Floyd, Cleveland: Artificial Pneumothorax as a Treatment of Pulmonary Tuberculosis, *Arch. Int. Med.*, April, 1912, p. 452; abstr., THE JOURNAL, May 4, 1912, p. 1308.

Montgomery, Charles M.: Pleural Effusion Due to Artificial Pneumothorax, THE JOURNAL, Feb. 15, 1913, p. 494.

Lillingston, C.: Pneumothorax Treatment of Phthisis, *Lancet*, London, Dec. 14, 1912; abstr., THE JOURNAL, Jan. 18, 1913, p. 244.

Hamman, L., and Sloan, M. F.: Induced Pneumothorax in Treatment of Pulmonary Disease, *Bull. Johns Hopkins Hosp.*, February, 1913; abstr., THE JOURNAL, March 1, 1913, p. 696.

Aron, E.: Therapeutic Artificial Pneumothorax, *Berl. klin. Wchnschr.*, Feb. 17, 1913; abstr., THE JOURNAL, March 22, 1913, p. 948.

Lenaert, E.: Artificial Pneumothorax in Pulmonary Tuberculosis, *Arch. gén. de méd.*, March, 1913; abstr., THE JOURNAL, May 10, 1913, p. 1497.

Chitty, H.: Artificial Production of Pneumothorax in Phthisis by Injection of Nitrogen, *Med. Press and Circular*, Nov. 13, 1912; abstr., THE JOURNAL, Jan. 4, 1913, p. 88.

Harris, S. T.: Relation of Gas Embolism to Production of Artificial Pneumothorax, *South Med. Jour.*, May, 1913; abstr., THE JOURNAL, June 7, 1913, p. 1836.

Fagiuoli, A.: Artificial Pneumothorax, *Riforma med.*, Oct. 19, 1912; abstr., THE JOURNAL, Nov. 30, 1912, p. 2013.

Weiss, A.: Complications Liable in Treatment with Artificial Pneumothorax, *Beitr. z. Klin. d. Tuberk.*, 1912, xxiv; abstr., THE JOURNAL, Nov. 9, 1912, p. 1752.

Lapham, Mary, E.: The Treatment of Pulmonary Tuberculosis by Compression of the Lung, THE JOURNAL, Sept. 14, 1912, p. 888.

Piesticker, F. and Vogt, H.: Artificial Pneumothorax for Children; Ten Cases, *Monatschr. f. Kinderh.*, 1912, xi; abstr., THE JOURNAL, Oct. 26, 1912, p. 1584.

Finzi, G.: Artificial Pneumothorax Most Effectual Means to Arrest Tendency to Hemoptysis in Tuberculosis, *Gazz. d. osp.*, July 2, 1912; abstr., THE JOURNAL, Aug. 10, 1912, p. 492.

Finzi, G.: Artificial Pneumothorax in Treatment of Hemoptysis, *Policlinico*, Rome, Sept. 22, 1912; abstr., THE JOURNAL, Nov. 2, 1912, p. 1664.

Paternoster, D.: Induced Pneumothorax in Treatment of Pulmonary Tuberculosis, *Semana méd.*, April 25, 1912; abstr., THE JOURNAL, July 6, 1912, p. 78.

Ferretti, M.: Artificial Pneumothorax in Treatment of Pulmonary Tuberculosis, *Riforma med.*, June 8, 1912; abstr., THE JOURNAL, July 27, 1912, p. 318.

Harris, S. T.: Treatment of Pulmonary Tuberculosis by Compression of Lung, *Jour. Med. Assn. Georgia*, August, 1912; abstr., THE JOURNAL, Aug. 24, 1912, p. 675.

Sorgo, J.: Operative Treatment of Pulmonary Tuberculosis, *Wien. klin. Wchnschr.*, Aug. 22, 1912; abstr., THE JOURNAL, Oct. 5, 1912, p. 1333.

Jacquerod: Artificial Pneumothorax in Treatment of Pulmonary Tuberculosis; Twenty-Three Cases, *Rev. méd. de la Suisse romande*, September, 1912; abstr., THE JOURNAL, Nov. 9, 1912, p. 1751.

Otis, E. O.: Artificial Pneumothorax in Advanced Unilateral Cases of Pulmonary Tuberculosis, *Boston Med. and Surg. Jour.*, Oct. 31, 1912; abstr., THE JOURNAL, Nov. 16, 1912, p. 1826.

Gekler, W. A.: Treatment of Pulmonary Tuberculosis with Artificial Pneumothorax, *Jour. Indiana Med. Assn.*, Oct. 15, 1912; abstr., Nov. 2, 1912, p. 1644.

Renon, L.: Arrest of Acute Tuberculosis by Artificial Pneumothorax, *Arch. gén. de méd.*, October, 1912; abstr., THE JOURNAL, Dec. 7, 1912, p. 2098.

Langman, C.: Artificial Pneumothorax in Pulmonary Tuberculosis, *Hygiea*, Stockholm, October, 1912; abstr., THE JOURNAL, Dec. 28, 1912, p. 2332.

Balboni, G. M.: Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax, according to Method of Forlanini, *Boston Med. and Surg. Jour.*, Nov. 28, 1912; abstr., THE JOURNAL, Dec. 14, 1912, p. 2184.

Balboni, G. M.: Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax, According to Method of Forlanini; Report Of Twenty-One Cases, *Boston Med. and Surg. Jour.*, Dec. 15, 1912; abstr., THE JOURNAL, Dec. 21, 1912, p. 2285.

PRESCRIBING FOR SYMPTOMS

To the Editor:—I wish to protest against the practice of prescribing for the mere symptoms of disease in answer to a correspondent as exemplified in "Treatment of Indicanuria" (Queries and Minor Notes, THE JOURNAL, Nov. 29, 1913, p. 2000). One can hardly believe it necessary to call attention soberly and critically to the simple fact that the underlying condition causing the symptom indicanuria is to be discovered, that it is this condition which is to be treated, and that it may be anything from simple stasis due to lack of opportunity to carcinoma and diverticulitis. Why not also prescribe for "sour eructations," for "biliousness," for "menorrhagia"?

W. A. GROAT, M.D., Syracuse, N. Y.

ANSWER.—The protest plainly comes from a not too careful reading of the question. The answer refers to the one case about which the question is asked. Indicanuria, in any case, depends on putrefactive changes and its presence for five years with, apparently, no other symptoms certainly shows that no serious condition is present, and that, in this case, putrefactive changes in the intestine constitute the "causative factor." It is gratifying that we have readers so critical as to object both to prescribing for symptoms and to the warning to look for the cause; but a practitioner is to be congratulated if the diseases he sees are so clearly marked that he is always able to discover a cause and never finds himself compelled, as in "biliousness," "indicanuria" or "menorrhagia," to follow a routine treatment of symptoms until an obscure cause can be discovered. It occasionally happens, also, that the warning that causative factors should be looked for is needed by a routine practitioner.

PROPHYLAXIS AGAINST CARRYING INFECTIONS BY PHYSICIAN

To the Editor:—Can you tell me if the following procedure in visiting patients with contagious diseases is safe?

I wear a cap, gown and gloves which I carry in a separate grip. After taking them off I pour a dram or two of formaldehyd 40 per cent. solution on them and close the grip. I usually do not use them again for at least twenty-four hours. Does such a process kill the germs so that I shall not expose another patient to the disease or contaminate myself in putting on the outfit again? I know a number of men who use this method.

C. E. C., Kansas.

ANSWER.—The opinion is growing that the infectious diseases, except those known to be transmitted by insects, are spread directly from one living being to another, and that fomites play little or no rôle in their transmission. At present, however, the precaution of wearing such an outfit as that described is a proper one and indicates that care is used not to spread infection. The use of the formaldehyd solution in sufficient quantity to produce by its evaporation in the grip a strong gas would undoubtedly have a disinfecting

effect; not so much, however, in the dry state as in connection with steam or vapor. Disinfection with formaldehyd or sulphur is more efficient if the articles to be disinfected are wet, as more of the formaldehyd or sulphur dioxid gas is absorbed.

WAR ON THE RAT

To the Editor:—Some time ago I saw an article in the Waterville *Sentinel* entitled, "War on the Rat." I wrote them in regard to it and they answered that they thought that if I wrote you I could get the information that I wanted.

J. J. CROWE, M.D., Bangor, Me.

ANSWER.—The following is a list of articles on this subject:

Creel, R. H.: The Rat, a Sanitary Menace and an Economic Burden, Reprint 135, U.S.P.H.S., July 4, 1913.
McCoy, George W.: Notes on the Bionomics of Rats and Ground-Squirrels, Reprint 94, U.S.P.H.S.
Heiser, V. G.: The Rats of Our Cities, *Pub Health Rep.*, July 25, 1913, xxviii, No. 30.
Rat-Proof Buildings, Current Comment, THE JOURNAL, May 10, 1913, p. 1466.
Simpson, F.: Rat-Proofing: Its Practical Application in the Construction or Repair of Dwelling or Other Buildings, Reprint 122, U.S.P.H.S., April 11, 1913.
Grubbs, S. B., and Holsendorf, R. E.: Fumigation of Vessels for the Destruction of Rats, Reprint 132, U.S.P.H.S., June 20, 1913.
Creel, R. H.: The Rat: Its Habits and Their Relation to Anti-plague Measures, Reprint 119, U.S.P.H.S., Feb. 28, 1913.
Simpson, F.: Rat-Proofing: A Municipal Sewer System, *Pub. Health Rep.*, Oct. 31, 1913, xxviii, No. 44.

Any of the foregoing pamphlets may be obtained by addressing the Superintendent of Documents, Washington, D. C., enclosing five cents for each pamphlet desired.

TOXICITY OF MALACHITE GREEN

To the Editor:—I have a patient who worked for several months in a broom-factory where the work necessitated his dipping his hands in the "broom-green" solution each day. After dipping the corn he assisted in placing the wet bundles of corn in the bleaching-room. In this room, lump sulphur is ignited and the corn is shut up tight until the following day when, after opening the room, he assisted in carrying this bleached corn to his place of work and had occasion to handle this bleached and dyed corn more or less the remainder of the day. This "broom-green" is known commercially under the name of malachite green, and chemically as the zinc double chlorid of tetramethyldi-para-amido-triphenyl carbinol. This man denies syphilitic infection and asserts that the perforation of his soft palate and nasal septum is caused by the chemicals and dust. Will you tell me something of the action of this chemical and give your opinion as to the plausibility of his assertion?

J. G. BAKER, M.D., Mattoon, Ill.

ANSWER.—Malachite green has been used as a confectioner's color, and is stated by a number of authors to be non-poisonous. On the other hand, Penzoldt says:

> One hundred mm. per kilogram body-weight of rabbit, or 70 grains per 100 pounds, injected subcutaneously, caused after the third day motor paralysis and occasional cramps, which resulted fatally at the end of the ninth day.

According to Lewin:

> In the case of one workman, in contrast with others who had long been unaffected by this substance, itching, burning, inflammation and swelling of hands and feet, and formation of blisters occurred.

INGREDIENTS OF PA-PAY-ANS (BELL)

To the Editor:—Please inform me if Pa-Pay-Ans (Bell) contains drug ingredients other than those stated on their printed label.

D. M. HOYT, M.D., Philadelphia.

ANSWER.—An analysis of Pa-Pay-Ans (Bell) was included in the report of the Council on Pharmacy and Chemistry rejecting the product (THE JOURNAL, Aug. 14, 1909, p. 569). While the analysis did not prove the presence of any ingredient not declared by the manufacturer, it failed to find one of the constituents claimed to be present—the constituent after which the medicine appears to have been named, namely, papain.

FREEDOM OF THE SOUTH AND SOUTHWEST FROM HAY-FEVER

To the Editor:—Can you inform me what regions of the West and Southwest are free from hay-fever?

C. C. BASSETT, Goodland, Ind.

ANSWER.—We have no definite statement as to any special regions of the West and Southwest which are free from hay-fever, but in general the disease is less prevalent in that section than in other parts of the United States. Hollopeter cites Wyman and Beard as regarding that portion of the United States west of the Mississippi River as free from the disease. It is generally regarded that the disease is not found south of the thirty-fifth parallel of latitude.

LITERATURE ON SWEDISH SYSTEM OF PHYSICAL TRAINING

To the Editor:—Can you refer me to some of the recent literature dealing with the Swedish system of physical training?

WENDALL DAVIS, M.D., Washington, D. C.

ANSWER.—The following list contains references to recent articles on this subject:

Diller, T.: Massage and Massage Operators in City of Pittsburgh, *Pennsylvania Med. Jour.*, January, 1913.
Pope, C.: Massage, *Southern Med. Jour.*, May, 1913.
Kirchberg, F.: Massage and Graduated Exercises in Kidney Disease, *Therap. Monatsh.*, October, 1913.
Steele, M. J.: Hydrotherapy and Massage, *West Virginia Med. Jour.*, July, 1911.
Joffe, M.: Pressure Massage of Nerves, *Berl. klin. Wchnschr.*, Dec. 20, 1911.
Schule, A.: Massage of the Nerves at Their Emerging Points, *München. med. Wchnschr.*, Dec. 20, 1911.

DOES SMALL-POX PROTECT AGAINST BOVINE VACCINATION

To the Editor:—Referring to the case reported by Hochheimer in THE JOURNAL, Dec. 6, 1913, p. 2089, the following may be of interest:

During 1908-1910 I was director of the Siamese government serum laboratory, and in testing small-pox vaccine before sending it out for use, I vaccinated many persons. Among those vaccinated were forty-six adults, each of whom had had an attack of small-pox during childhood. They ranged from 25 to 40 years of age, and of these vaccinations, twenty-six, or 56.5 per cent., were successful, thus showing that in a goodly percentage of cases variola in childhood does not confer immunity against vaccinia, lasting more than to middle age. The result also justified the recommendation of the Minnesota Board of Health, which would vaccinate all exposed to small-pox when not protected by either a recent attack of small-pox or a recent successful vaccination.

RALPH T. EDWARD, A.M., M.D., Ceylon, Minn.

Medical Economics

THIS DEPARTMENT EMBODIES THE SUBJECTS OF POST-GRADUATE WORK, CONTRACT PRACTICE, LEGISLATION, MEDICAL DEFENSE, AND OTHER MEDICOLEGAL AND ECONOMIC QUESTIONS OF INTEREST TO PHYSICIANS

MEDICAL INSURANCE ABROAD

Discussion and interest regarding the experiments being made in different countries for the compulsory insurance of the working classes and those employed at small salaries is increasing. In Germany and England, the medical profession is in a high degree of turmoil over the operation of the laws on this subject. In Denmark, a law has been in operation for six years. In Russia, an insurance law against disease and accidents went into effect last June. In Norway, the operation of the law dates from July, 1911. In Australia, while no law has, as yet, been enacted, the subject is one of vital interest to the medical profession there and is being freely discussed.

CONDITIONS IN GERMANY

Germany has had a more protracted experience with compulsory insurance than any other nation, but has not, as yet, actually worked out a plan of administration which is free from serious objections. The German medical profession is at present in as marked a position of opposition to the German insurance law, as is the medical profession in Great Britain to the British law.

A general meeting of the medical profession held in Berlin, October 26, decided that after Jan. 1, 1914, the insured population of Germany, with the exception of Dresden, Hamburg and Berlin, should not receive any treatment from physicians through the insurance societies, unless these societies acceded to the demands of the physicians, or unless the government saw fit to intervene. The meeting was called by the president of the National Federation of Medical Societies, and was attended by 458 representatives of 384 medical societies, with a total membership of 21,207 physicians. The situation in Germany is a plain issue between the physicians on the

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one hand and the insurance societies on the other. The resolution adopted by the meeting stated clearly that there was no intention on the part of the physicians represented to refuse medical services to the members of the insurance societies as individual patients; the refusal was to treat them as members of the societies. Unless the demands of the physicians are accepted, they propose, after the first of the year, to treat each individual as a private patient and not as a member of an organization. In a word, the proposal is to go back to the original system of individual professional relations between physician and patient, without any middleman or intermediate party. The points under dispute are numerous and intricate, and are embodied in forty-four clauses which have been discussed in detail by the profession of Germany for some time past. These differences of opinion have to do with the right of physicians to representation on the administering boards of the insurance societies, and the right of patients to choose the physicians whom they prefer, the method of organization and administration of the medical boards, the handling of complaints, the appointment of medical officers and the determination of their duties, the remuneration for physicians and the periods and character of the contracts between physicians and insurance societies. This declaration of principles represents the minimum demands of the physicians. The compensation asked for is a per capita fee of 5 marks. This is not to include night visits, attendance on confinements or abortions, treatment of persons who have only a legal but no medical claim on sick benefits, or the treatment of families of insured persons. For all of these services, special arrangements are to be made.

Following the representative meeting of the general profession of Germany, the Federation of Insurance Societies not only refused to accede to the demands of the physicians, but refused to recognize the right of physicians to organize the profession for the protection of their individual rights. This situation, which reminds the American reader of the conflicts between corporations and employees, and the fight between these conflicting parties over the right of the working men to organize and the recognition of the unions, led the Berlin Medical Society to take an action which is rarely necessary, namely, to call a special meeting to discuss medical politics. On November 12, the Berlin Medical Society met in extraordinary session with Professor Orth in the chair. The leading members of the profession of Berlin strongly endorsed the stand taken by the representative meeting and pledged their support to the movement for professional independence. Professor Kraus said that the insurance societies had no right to dictate terms to physicians, or to insist on choosing physicians for patients. He advised the medical profession to remain "united and firm, so that you may be able to preserve for your profession its independent freedom." Dr. Munter declared that the scientific and economic decline of the medical profession must follow the imposition of oppressive terms of contract practice. He said that the insurance societies had formed themselves into a protective organization and that they were endeavoring to prevent any similar organization among physicians. A motion was unanimously adopted declaring that the demands of the insurance societies seriously imperiled the freedom and independence of the medical profession, and that the Berlin Medical Society pledged its wholehearted support to the medical profession in Germany.

SITUATION IN ENGLAND

In England the situation is quite as serious, even if somewhat less tumultuous. Nearly a year's operation of Lloyd-George's insurance act has disclosed many weaknesses and difficulties in administration. The regulations governing the act are being revised and a general discussion is going on regarding the exact terms of the revision. As an illustration of the practical workings of the act, a special commissioner of the London *Lancet*, in a recent issue, writes interestingly of the situation in Derby and Derbyshire. Of the 560,129 inhabitants in Derbyshire, outside of Derby, 178,294 came under the provisions of the insurance act. Practically all of the local physicians, to the number of about 300, are on the "panel," that is, they have enrolled as desiring to treat persons under the provisions of the law. This gives an average of about 600 patients to each physician. One practitioner had about 3,000 insured persons on his list, and was responsible for the medical care of over 700 families. Difficulties regarding the payment of mileage has arisen, as well as practical problems regarding the dispensing of drugs, the filling of prescriptions, etc. One interesting result, according to the writer in the *Lancet*, is that the act is doing away with the "prescribing chemists," that is, with the practice of druggists prescribing for customers. This fact is apparently welcomed by the high-grade druggists as well as by physicians. The *Lancet* says, "The custom of going to the chemist for advice, as well as for a bottle of medicine, is dying out rapidly, as the public argues, why consult a chemist when it does not cost any more to have a doctor?"

Another difficulty is malingering on the part of patients. The working man has to pay a fixed amount for medical and sick benefit. It does not cost him any more to be sick than it does to be well. With the large number of patients which the insurance doctors have to see and examine, it is impossible to make a careful examination in all cases. The friendly societies are endeavoring to prevent malingering by sending inspectors of their own to inspect cases in which they suspect deception. This has led to considerable controversy.

The bulk of the discussion at present, however, turns on the new regulations. These are most exhaustive, covering twenty-three pages of fine print of a supplement in the *British Medical Journal*, and containing detailed provisions for almost every part of the law. An explanatory memorandum summarizing the regulations, states that the new provisions do not affect the amount available for remuneration, but have to do principally with the method of calculating the number of persons for whom the physician is entitled to compensation. All sorts of difficulties have arisen regarding persons removing from one district to another, and the amount of compensation which the physicians in the different districts should receive on their account. It has been found impossible to keep an accurate register showing the total number of insured persons in any district at any one time, owing to the difficulty involved in the notification of removals and the mechanical work of correcting the registers. It has been found necessary, therefore, to adopt some plan by which the number of persons for whom the physician is entitled to compensation shall be averaged rather than directly enumerated. Considerable difficulty has also been encountered in dealing with complaints, and it has been found necessary to enlarge the powers of the committee dealing with this subject.

The general situation in England seems to be that the medical profession has gradually and under protest submitted to the new law and that it is now making an effort to secure as favorable regulations for its administration as possible. The *British Medical Journal*, in a recent issue, asserts that the insurance scheme is being made a counter in the game of party politics, and that the two dominant parties in the British House of Commons are using it as a political issue without regard to its merits. Leaders on both sides, the *Journal* says, are trying to conciliate the managers of the friendly societies. Mr. Bonar Law, in criticizing the act, said that many of the friendly societies were drifting rapidly into insolvency, that the act was having the worst possible effect on the character of the people, that the details of the act were not to be cured by amendments or regulations, and that, if his party were given an opportunity, it would appoint a committee to investigate the entire subject and to report whether it would not be possible, in the interest of the nation, to turn the entire scheme into a voluntary instead of a compulsory system.

Mr. Winston Churchill, in replying to Mr. Law, challenged his statements and asserted that it was one of the best administrative achievements of the century, although in force only two years and working for only nine months. According to Mr. Churchill there were 13,700,000 persons actually insured through 233 insurance committees, and 23,500 societies and branches. Twenty-two million visits had been made by 20,090 physicians at a cost estimated at £4,500,000 (about

$22,000,000). Nearly twelve million cases had been treated and nearly £5,000,000 (about $24,000,800) had been disbursed in meeting sickness claims. Seven hundred and fifty thousand babies had been born of mothers cared for under the provisions of the law, and £1,200,000 (about $5,850,000) had been paid out in the form of maternity benefits. Mr. Churchill insisted that no voluntary system had ever in the past met the case of those needing help, and that such a system would release the employer from any obligation and would place the entire burden on the workingmen and the state, with the result that the friendly societies would be deprived of nearly half their income and would be actually bankrupt as a result.

The *British Medical Journal*, commenting on Mr. Churchill's statements, says that if it is true that 22,000,000 visits have been paid at an expense of £4,500,000, this would indicate that the average payment for each visit was 4s. 1d.—about a dollar. The most important conclusion to be drawn from his figures, however, is that the average cost to the medical benefit fund of each case treated during the nine months of operation of the law was 7s. 6d.

IN RUSSIA

In Russia, an insurance law against disease and accidents has been enforced since last June. This law applies to all workers, the administration of the sick-fund being managed by representatives elected by the working men and the employees. Medical aid included first aid and care in cases of childbirth, and also drugs in all cases. Funeral expenses are paid in case of death. Employees contribute at the rate of from 1 to 3 per cent. of their wages. Employers contribute two-thirds of the amount contributed by the workmen. The government does not contribute anything to the fund, but has a general oversight of its administration.

IN NORWAY

In Norway a compulsory insurance act went into effect in July, 1911. There, the medical profession was well organized, practically every physician in the country belonging to the Norwegian Medical Association. The physicians, as represented by the association, had no trouble in making acceptable arrangements with the government, securing free choice of physicians on the part of the patients, and payment on a scale in proportion to the amount of work done. The fee table is elaborate and detailed and has been on the whole satisfactory to the medical profession. The result, according to the *British Medical Journal*, has been a marked increase in the demand for medical attendance, those affected by the law going to physicians at once when in need of treatment.

UNDER CONSIDERATION IN AUSTRALIA

In Australia, the subject is under consideration. At the annual meeting of the Melbourne Medical Society an address was delivered by Dr. J. Ramsay Webb on the subject of medical politics. It was really devoted to a discussion of the economic policy of the profession rather than to politics in the sense in which the word is understood in this country. Discussing medical insurance in Australia, Dr. Webb said that the total membership of the friendly societies in that country in 1912, was 530,309. On the assumption that each workman had an average of three persons dependent on him, this would amount to 2,120,000 persons for whom medical attendance was provided by the friendly societies. This is more than 40 per cent. of the total population. The cost of such services to the friendly societies is estimated at from 4 to 5 shillings per annum. Dr. Webb compares this situation with that of Germany, which, after twenty-six years of operation, only 22 per cent. of the population was affected, while in Denmark, sixteen years of operation of the voluntary system, had reached only 23 per cent. His principal argument is that the adoption of a compulsory system under the control of the state in place of a voluntary system under the control of the friendly societies would "pervert the self-respecting, public-spirited lodge members to the shameless, rapacious receivers of pensions."

As has been frequently pointed out in THE JOURNAL, the entire subject is one of the utmost importance and interest to the medical profession and should receive the careful attention and study of physicians in this country.

Book Notices

ELEMENTARY CHEMISTRY. With Special Reference to the Chemistry of Medicinal Substances. By H. M. Gordin, Professor of Chemistry in the Schools of Pharmacy and Dentistry of the Northwestern University. Volume I. Inorganic Chemistry. Cloth. Price, $3. Pp. 482, with illustrations. Chicago: Medico-Dental Publishing Company, 1913.

Pharmacy schools do not require college work as a prerequisite to admission. Yet to enable their students to pass the pharmacy boards, teachers must make a pretense of covering in a short two-years' course, which, in its pretensions, will put a university curriculum to blush, everything from the fundamentals of physics and chemistry to advanced organic chemistry with quantitative chemistry. The difficult task which is set for the author of a "pharmaceutical chemistry" is evident. In this case the task was made still more difficult in that Gordin was obliged also to adapt his book to the needs of dental students. Altogether he has done his task well. The book presents a large mass of carefully selected chemical data.

While entirely too little use is made of modern chemical theories, the facts set down are almost always in accord with our present knowledge. This can be said of few pharmaceutical chemistries. That this accumulation of data about general chemical and physical matters and of special pharmaceutical and dental information has resulted in a text that is a bit dry was to be expected.

Gordin's book is intended for those studying for or engaged in the practice of medicine, pharmacy and dentistry. If adapted for dentistry and pharmacy classes, the book is not adapted to chemistry instruction given in medical schools. Students in medical schools should have obtained their primary instruction in chemistry before they took up the study of medicine, and, moreover, the medical curriculum is too well filled to permit a course in technical chemistry such as that contained in the book under discussion. Nevertheless, both the medical student and the practicing physician will probably find this a useful book of reference for information about inorganic drugs.

TREATMENT OF TUBERCULOSIS. Ordinary Therapeutics of Medical Men. By Albert Robin, Professor of Clinical Therapeutics at the Paris Faculty of Medicine. Translated by Dr. Léon Blanc and H. de Méric. Cloth. Price, $7 net. Pp. 616. Philadelphia: P. Blakiston's Son & Co., 1913.

While it is usually assumed that the rapid spread of information has abolished national boundaries so far as science is concerned, there seem to be certain exceptions to this rule. The view of tuberculosis entertained by Robin seems to have been neglected outside of France, although his assertions, if true, should point the way to a successful therapy and especially to a more efficient prophylaxis. Briefly, Robin's theory is this: Tuberculosis is preceded by a state of predisposition which is characterized by wasting and emaciation, and occurs in persons who present certain physical characteristics. Physiologically this period is characterized by two phenomena. The first is an increased rapidity of the respiratory exchanges so that more oxygen than normal is taken in by the lungs; and not only is a greater amount of carbon dioxid excreted, but also a portion of the oxygen disappears without being represented by the excreted carbon dioxid. This portion of oxygen is also greater than in normal persons. The second phenomenon is a demineralization of the body, a greater excretion of the inorganic constituents of the tissues than is compensated for by the food intake. This demineralization is also shown by a lessened content of the blood and other tissues in inorganic constituents, especially calcium, than is found in the normal state. This condition of excessive wasting or accelerated metabolism Robin regards as essentially the first stage of consumption. To this condition infection with the bacillus of Koch adds an increased impulse, so that excessive rapidity of respiratory exchange and demineralization, especially in regard to calcium, become important processes in pulmonary tuberculosis, a fact which has not been commonly recognized by pathologists. This condition consti-

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tutes not only preparatory soil for the implantation of the disease, but also especially favorable culture-medium for its further propagation. One peculiarity is revealed by Robin's analysis of tuberculous lung tissue: While the blood and other tissues of the consumptive contain less than their normal contents of calcium, and the bones show evidence that lime has actually been withdrawn from them, the healthy parts of the lung adjoining the diseased portions show an increased amount of calcium, indicating, in Robin's opinion, that the calcium plays a defensive rôle in protecting the tissues against the infection.

On these data Robin founds a comprehensive plan of treatment of consumption and tuberculosis. Here it may be remarked that he uses these terms in a somewhat different sense from the usual one. Tuberculosis is, as it were, something added to the consumptive state. He transposes Niemeyer's celebrated dictum and says that "the greatest danger which threatens a consumptive is to become tuberculous." The indications for treating the disease are given under five headings: preventive medication, remineralization, direct antiseptic medication, local medication and antitoxic medication.

Robin uses tuberculin in doses just sufficient to provoke a focal but not a general reaction, hoping thereby to produce a stimulant or counterirritant effect on the focus or infection and the healthy surrounding tissues.

Space is lacking to criticize the fundamental assertions on which the theory of Robin is based. One may be permitted to ask, however, how the determination of the proportions of minerals in a tissue can prove a demineralization. May not this relative decrease in the amount of inorganic constituents reckoned on the weight of the fresh tissue be due in fact to an increase of contained water? Whether or not a similar criticism applies to his urinary determinations we are not able to ascertain from the figures in the book. Assuming the phenomena to be correctly determined, the question arises, May not this accelerated metabolism be due to a tuberculosis already existing? It is now pretty generally accepted that most persons acquire tuberculosis in infancy or early childhood; may not the symptoms observed in predisposed persons be really the slight but persistent action of an unhealed tuberculosis?

THE PRACTITIONER'S VISITING-LIST, 1914. Leather. Price, $1.25. Philadelphia: Lea & Febiger.

THE PHYSICIAN'S VISITING LIST FOR 1914. Sixty-Third Year of Its Publication. Leather. Price, $1 net. Philadelphia: P. Blakiston's Son & Co.

MEDICAL RECORD VISITING LIST FOR 1914. Leather. Price, $1.25. New York: William Wood and Company.

The Physician's Visiting Lists offered by various publishers this year are, as usual, very attractive and useful. All of them contain special memorandum pages for each month ruled for each date, and amount and ledger page. In addition there are special pages for miscellaneous memoranda, obstetrical cases and practice, vaccinations, patients' and nurses' addresses and cash accounts. There are various calendars, tables, dosage lists, etc. All are well known, practical and attractive, and probably every physician has his particular choice.

THE DOCTOR IN COURT. By Edwin Valentine Mitchell, LL.B. of the Massachusetts Bar. Cloth. Price, $1. Pp. 152. New York: Rebman Company, 1913.

This book contains a practical and interesting discussion of physicians' relations to the courts, and of the general principles of the laws affecting them. The first chapter is the most interesting and valuable to the physician who but seldom goes on the witness-stand. It contains advice that is well worth heeding, and the witness, if he follows it, would make a better spectacle than does the average doctor when giving evidence. The remaining chapters discuss the laws, including those on the regulation of the practice of medicine, which affect physicians and with which every physician should be familiar. While not large or exhaustive, this work is sufficiently complete for all ordinary purposes. The language is clear and non-technical. We commend the book to those who may be called into court, which means to all in the practice of medicine or surgery.

Miscellany

The Fundamental Basis of Nutrition

From an Address by Dr. Graham Lusk before the New York Academy of Medicine

It seems as though mankind has a right to a knowledge of the value of foods which a bountiful Nature has provided for human use. Even among educated persons there are the grossest errors of judgment regarding the nutritive value of a hen's egg, and few of those who eat at restaurants realize that the greater quota of the nourishment brought to them is not in the specific dish served but in the bread and butter which ostensibly is presented as a gift. The function of nutrition is to furnish fuel to the organism that the motions of life may continue, and furthermore, the workshops of life are in a constant state of partial breaking down and materials must be furnished to repair the worn-out parts. In the fuel factor and the repair factor lies the science of nutrition.

The heat given off by the body is found to be equal to the quantity of heat which would have arisen from the oxidation of just that quantity of protein, fat and carbohydrate estimated to have been destroyed. Drs. Du Bois and Warren Coleman discovered that a typhoid fever patient, during a period of five hours of rest in their calorimeter, produced the same number of calories as it was calculated that he should produce from the materials that were oxidized in his body. The contemplation of such a result drives home the fact that if the typhoid fever patient is to be kept from losing his own body-muscle and fat, he must be given the equivalent of 422 calories in food substance during a five-hour period. Measurement of the total heat production becomes a measure of the intensity of the life processes. All well-nourished mammals produce the same number of calories per square meter of surface. A normal man resting in bed in the morning, having been without food for fifteen hours, will manifest a minimum level of heat production. The basal heat production of an average man weighing 70 kg. will be 70 calories per hour, or 1,680 calories in twenty-four hours. If food were taken extra heat would be produced, but not exceeding 10 per cent. of the basal heat production, or 7 calories per hour, or 168 per day, so that the maintenance requirement of this man resting in bed was 1,848 calories daily. Beyond this the amount of fuel needed depended on the amount of work done. The normal man requires exercise and this calls for an additional amount of fuel. A man leading a sedentary life and taking perhaps two hours of exercise daily needs in round numbers 2,500 calories daily in order to provide proper nourishment and repair. Men doing heavy physical labor require at least 3,000 calories. A boy of 12 years requires 1,500 calories daily, and a baby when first born requires 100 calories. In fever hyperthyroidism and conditions in which the heat production of the body is far above the normal, increased nourishment is indicated. While the body may suffer from the deficiency of certain elements as calcium or iron, the really important material to be treasured and protected is the body protein. Proteins are especially valuable if they contain an array of units which when reunited in the body form body proteins. Proteins in which one or more of the necessary units are lacking can never be reconstructed into body proteins. Such inferior proteins occur among the plants. Plant proteins are reconstructed into beef proteins and thus beef proteins attain a higher biologic value than plant proteins. There can be no doubt, in view of the results of experiment, that meat, fish, milk and egg proteins possess superior value to the vegetable proteins. The proteins of rice and potato are of more value than those of bread, beans and Indian corn. Such facts make it possible to classify proteins into groups according to their physiologic value, and as milk is now sold in three grades, in like manner the protein of foodstuffs could be labeled A, B and C according to their physiologic value, and to Group D might belong gelatin and some other proteins that cannot replace body protein that is continually wearing away.

Protein is usually taken in excess of that bare requirement which is measured by the quantity necessary to repair the tissues. This excess is oxidized and used as fuel just as are fats and carbohydrates. Protein has one property out of all proportion to that possessed by the other foodstuffs in that it largely increases the heat production in the body. Persons maintained on a low-protein diet may suffer intensely from the cold. Glycocoll is one of the units that cause a marked increase in the heat production. In diabetes ingested glycocoll is completely converted into sugar without undergoing oxidation, and hence it acts as a chemical stimulus and not in virtue of its energy content. This heat-producing action is effected by all kinds of protein, by those of meat, fish, milk, egg, and such incomplete proteins as gelatin. In order to obtain the warming effect it is not necessary to purchase so costly an article as beef. Rubner believes that there should always be an excess of protein-constructive material in the diet so that if after physical exhaustion there is a depletion of the glycogen reserve there may be building units in reserve to quickly repair the tissue destroyed. It is not desirable for the laboring man to take the minimum amount of protein.

It has been known for a long time that life cannot be maintained on an absolutely pure mixture of salts, fats, carbohydrate and protein. The human organism is extremely sensitive to certain substances in minute quantities, as, for instance, epinephrin, the active constituent of the suprarenal glands, which is present in the blood in one part to 100,000,000 and is essential to human life. The relation of polished rice to beriberi has been recognized, and Funk has sought to isolate those substances, termed by Funk vitamins, which prevent beriberi and are necessary to the normal growth and nutrition of the animal tissue. If meat is eaten their direct ingestion from the plant becomes unnecessary. These vitamins enter into the composition of normal maternal milk; if a mother has beriberi these substances will be lacking in her milk and consequently the infant will also have the disease. Beriberi and scurvy do not exist in the United States, they only occur when a one-sided diet deficient in vitamins is depended on.

We may now consider the high cost of living in the light of scientific knowledge of food value. The efficiency of labor depends on its energy and constant repair, and it is certainly of no small account that the citizen should know how best to maintain the human machine at its maximum efficiency. The manufacturer of foodstuffs will not give this information; but if, through the medium of the schools and the press, every one knows that a man of sedentary habits requires 2,500 calories and a laboring man 3,000 calories and more, no one suffering from want will spend his money for a can of tomatoes which is little else than flavored water. It has been estimated that in a family of five comprising the father, a clerk, the mother, who does her own housework, two children, aged 9 and 6 years, and an infant 1 month of age, 7,750 calories are required daily. A study of the market values of staple foods in New York City, Jan. 28, 1913, showed that for an adult requiring 2,500 calories, or one-third as much as the entire family, the cost would not exceed 20 cents a day at the market price of fresh materials. When more than an average of 8 cents is expended for 1,000 calories of nutriment, the diet must include luxuries. The following market prices of various food staples shows the great variation in the price of 1,000 calories: glucose, 1⅗ cents; cornmeal, 2 cents; wheat flour, 2.5 cents; oatmeal, 2.8; canesugar, 3½; dried beans, 4; salt pork (fat), 4.5; rice, 5; wheat bread, 5½; oleomargarin, 7.5; potatoes, 7.5; butter, 10; milk, 10; smoked ham, 10.75; cheese, 11⅗; loin pork, 12.25; mutton (leg), 16.25; salt cod, 19.5; sirloin beef, 4; turkey, 40; fresh cod steak, 42. The relative amount of protein for the family of five is furnished by bread with the addition of 4/5 pounds of salt cod, or 3/5 pounds of smoked ham, or 4/5 pounds of cheese, or 2½ pounds of milk, or 1½ pounds of loin pork, or 1⅓ pounds of leg of mutton, or 1¼ pounds of cod steak, or 1⅓ pounds of sirloin steak, or 1½ pounds of turkey. It is evident that if each package of food were sold as containing so many calories, the widely heralded food value of such articles as Postum, for example, would "fold their tents like the Arabs, and as silently steal away." On the basis of these values it would cost a poor family from 50 to 70 cents a day for food; a family of moderate means where two servants are kept, from $1 to $1.40; and a wealthy family where six servants are kept, from $1.50 to $2.10. Whatever is spent above this is for waste or in the form of flavors of high price. Recently Miss Dorothy Lindsay made a report concerning the working classes in Glasgow in which she concludes that one of the main contributing factors of malnutrition among the poor is bad marketing. The experience of America in the matter of school lunches for the children of the poor shows that it is demonstrable economy on the part of the state to feed the undernourished child. But the state should also teach the mother the value of bread and milk, and that weak tea cannot take the place of milk in the nourishment of the child. In a study into the physiologic value of various food sold over the counter of Child's restaurants in this and other cities, F. C. Gephardt of the Russell Sage Institute of Pathology collected and analyzed 400 samples. For comparative standards bread and vintage champagne have been selected, neither of which was purchased in the restaurant.

FOOD VALUE OF PORTIONS, INCLUDING BREAD AND BUTTER WHEN SERVED IN CHILD'S RESTAURANTS

	Cost, Cents	Calories, Total	Protein, Per Cent.	Calories for Five Cents	Cost in Cents per 1,000 Calories
Bread	5	933	12	933	5
Apple pie	5	337	5	337	15
Boston pork and beans	15	828	12	276	18
Ham sandwiches	5	170	20	170	30
Corned beef hash	15	507	14	170	30
Beef stew	15	461	25	154	32
Club sandwich	25	469	20	52	61
Sliced pineapple	5	36	46	36	138
Tomatoes, lettuce mayonnaise	20	53	16	13	385
Pint of champagne	200	345	0	9	588

The extreme variability of the purchasing power of money for food stands here exposed in the lime-light. The government should take up this matter and give information regarding all foodstuffs sold in packages. The manufacturer could send his sample can to Washington to the Bureau of Chemistry, declaring that to be his standard and requesting information regarding his label. He should pay for this analysis as the patentee pays for his patent. If the government at any time finds the manufacturer of foods and "patent medicines" selling a material on the market of a different character from the standard deposited with the government, the manufacturer should be heavily fined. Manufacturers have complained that in other countries scientific men sit on the boards of directors of the manufacturers of foods and "patent medicines." In this country that sort of thing has been discountenanced and rightly so. The day of the sale of a man's scientific reputation and that of an institution with which he is connected has passed. The scientist has come to have sufficient altruism to believe that his services belong to all the people and not to a set of money-making individuals. Appeal is made to the understanding of physicians and of educated people of this country to take interest in this subject to the end that enlightened activity for the welfare of mankind may follow.

Shipping Live Fish in the Frozen State.—In the markets of Irkutsk, Siberia, fish are displayed for sale in the frozen state piled up like cordwood (see Nature's Cold-Storage Plant, quoted from *Am. Food Jour.*, THE JOURNAL, Oct. 19, 1912, p. 1429). Fish in cold storage are preserved frozen in slabs of ice. The latter method is now applied in the shipment of live fish. The method of shipping live fish in water is not feasible on account of the expense, as from 1 to 4 gallons of water are required for each pound of fish, according to the variety. Since the discovery by Pictet that fish may be frozen in blocks of ice without being killed, and that they

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will become as lively as ever after they are thawed out, a method has been devised for preparing them for shipment in ice. The method is described in the *Scientific American*. The fish in a large amount of water are placed in a closed tank, and oxygen under pressure is supplied. The greater portion of the water is then drawn off. The fish remain in good condition on account of the abundant supply of oxygen. The vessel containing the fish is then placed in a freezing tank and the fish are frozen into the ice formed. The blocks of ice containing the fish can then be piled up in the ordinary refrigerator car. On arrival at their destination the fish are put through a slow thawing process lasting ten hours, when they return to their normal state of active animation.

Health as a Community Asset.—To the extent that the inhabitants of a community are sick the community itself is diseased. The community has health only in so far as the people are free from disease. To a community health is a valuable asset. It insures prosperity. It attracts people. It increases the value of the land. Many letters are received daily at the Public Health Bureau at Washington from people who are contemplating buying land or moving from one state to another, asking about the health conditions of certain localities. They want to know whether there is much sickness in this or that locality, whether there is any malaria, much typhoid fever or tuberculosis, and whether there is a pure water-supply. People are thinking in these days of their physical welfare and have no desire to live in localities where insufficient attention is given to the prevention of disease and where there is more sickness than there should be. The community that has health has a distinct advantage in the competition for economic prosperity over the sick community.—John W. Trask, *Public Health Rep.*

Medicolegal

Charitable Associations Not Exempt from Liability for Failure to Guard Machinery

(McInerny vs. St. Luke's Hospital Association of Duluth (Minn.), 141 N. W. R. 837)

The Supreme Court of Minnesota, in affirming a judgment for the plaintiff, who was injured on a mangle while in the defendant's employ, holds that Section 1813 of the revised laws of that state of 1905, imposing on all persons and corporations owning or operating dangerous machinery the duty to cover or guard the dangerous parts thereof, so far as practicable, applies to charitable associations owning and operating such machinery, as well as to all other persons or corporations similarly situated. The duty thus imposed is absolute and not to be delegated, and a failure to discharge it renders the charitable association liable to its servants and employees who are injured in consequence of the neglect.

In reaching this conclusion, the court says that it is not to be understood as underestimating, or failing to appreciate to its fullest extent, the blessings bestowed on the destitute, and the poverty-burdened applicant for help. Its view is that the duty created by law for the protection of servants is absolute, and no employer should be exempt therefrom, except by action of the legislature. No public good can come from permitting one charitable corporation, by the failure of a duty imposed by law, to maim and disfigure its servants and employees, when, depending on the nature of the injury, their future welfare must of necessity be looked after by some other charitable association, public or private, or by already overburdened or poverty-stricken relatives and friends. No such situation should be brought about by an arbitrary rule of immunity from liability, applicable only to one class of persons, unless deemed by the legislature necessary to the existence and life of charitable associations.

Nor is the court to be understood as holding that the trust funds of the defendant may be applied to the payment of the verdict. That question was not involved. The defendant was not supported exclusively from such funds; on the contrary, its maintenance would seem from the evidence to come principally from patients who pay for services rendered them.

Physician's Right to Claim Safe Exempt

(Sterman vs. Hann (Ia.), 141 N. W. R. 934)

The Supreme Court of Iowa reverses a judgment against the plaintiff, a physician, who, it says, sought by an action in replevin to recover a half interest in a safe levied on by the defendant, as constable, under an execution, and claimed by the plaintiff to be exempt under the Iowa law, on the grounds that he was a physician and surgeon and used it in and about his business. He owned the safe in common with his wife, each owning an undivided half interest. It was, however, in his possession, and under his control, with the knowledge or consent of his wife, and he used it in and about his business for the purpose of keeping therein his professional instruments, books and accounts, and certain rare and valuable medicines. The defendant constable made no claim, under the execution, against the interest of the wife. Therefore, as against the constable, the plaintiff had the right to the possession of his wife's interest in the property, and if his interest in the property was exempt, as the court holds it was, he had the right to hold that, too, as against the levy of attachment. He, therefore, had dominion over the entire property. He had a right to take, use it, and keep it, and this right came to him from the other party having a joint interest with him in the property. He had dominion over the property, with the consent of his wife, and had a right to use it in connection with his business, and for the purposes for which it could, and would, be used were he the sole owner. The safe was exempt, in the hands of the plaintiffs, the same as office furniture and the supplies of a lawyer are exempt. In other words, a physician can hold, as exempt, a safe kept and used by him in his office in connection with his business as physician and surgeon, for the purpose of keeping therein his professional instruments, books and accounts, and medicines. It must be borne in mind that exemption laws are to be liberally construed; that they are given to the debtor to secure to him the necessary comforts of life for himself and family, and are enacted on the ground of public policy, for the purpose of saving debtors and their families from want, by reason of misfortune or improvidence, and should be so construed as to carry out the intent and purpose of the legislature.

Validity of Ordinance Prohibiting the Maintenance of "Museums of Anatomy"

(City of Chicago vs. Shaynin (Ill.), 101 N. E. R. 224)

The Supreme Court of Illinois holds constitutional an ordinance of the city of Chicago which provides: "It shall be unlawful for any person, firm or corporation to own, conduct or operate any exhibition commonly known as a museum of anatomy, or other exhibition, show or place of amusement which is open to the general public, whether admission thereto is restricted by sex and age or not, or whether a fee for admission thereto is charged or not, wherein the principal part of the exhibition is illustrative of the human anatomy, or wherein are exhibited any books, pamphlets, circulars, pictures, charts, diagrams, models, casts or other articles, paintings, drawings or designs of any kind illustrating or describing the genital organs, or containing any other obscene, lewd, indecent or immoral exhibition of any kind, when such museum or other exhibition is conducted for gain or profit, either directly or indirectly, or for the purpose of advertising or in connection with a place where medical treatment is offered or medicine is sold, or for any immoral purpose whatever."

The court says that if it be argued that the cure of the sexual diseases portrayed by these models is not an unworthy object, it may be answered that the exhibition of offensive and repulsive models on sexual subjects, which may pander to the morbid tastes and arouse the sexual desires of those who are attracted to the place, does not have any necessary rela-

tion to the unobjectionable results. When any business for treating sexual diseases is carried on with such objectionable features as, it must be, to violate the previsions of this ordinance, then such objectionable features may so far overcome the legitimate value of such business as to warrant suppression.

Even though there might be a doubt whether the kind of exhibition or business conducted in the place kept by the defendant tended to immorality, and there might be an honest difference of opinion as to whether it was advisable to suppress such business as a nuisance, there can be no question as to the right of the city council to exercise its discretion and declare, by ordinance, such places common nuisances. The court is disposed to think, also, that if this business was against decency or public morals, the ordinance could be upheld under the clause granting to municipalities the authority to pass and enforce all necessary police ordinances.

Value of Services Question for Jury—Expert Evidence Not Conclusive

(Fowle vs. Parsons (Ia.), 141 N. W. R. 1049)

The Supreme Court of Iowa holds that the question of the value of the services of a surgeon is for the jury, even though the evidence is undisputed. The court says that the plaintiff sued to recover $187.50 for his services in performing a surgical operation on the defendant's foot. The defendant admitted the performance of the services, but denied that they were of the value alleged. The plaintiff and his assistant testified that the services performed and medicines furnished were of the value of $187.50, and there was nothing in the defendant's evidence to contradict such evidence as to the reasonableness of the charges. On that a verdict was directed for the plaintiff for the full amount of his claim, with interest. But the defendant contended that, notwithstanding the fact that the plaintiff's evidence as to the value of the services was not disputed, it was still a question for the jury, and as his contention must, under the authorities, be sustained, the judgment rendered for the plaintiff on the directed verdict is reversed. The court does not say that the plaintiff's charges were unreasonable, nor does it express any opinion either way.

There is a class of cases in which skilled and experienced experts give their opinions, based in part on facts which have come within their own observation, or in which they state precise facts in science as ascertained and settled, holding that such opinions are entitled to great weight, and are perhaps binding on the jury if undisputed. At first glance, it might seem that the same rule would apply in a case like this one, where the witnesses were physicians and surgeons; but here the opinions of the experts related to the question of value alone.

It was said by the plaintiff that this case was an exceptional one; that he was a specialist at Milwaukee, and that the jury could know nothing of the value of such services. But the court would not be justified in changing the rule because the case was exceptional, if it were such. Cases may arise in which the appearance of the witness, his reasons given as a basis for his opinion, the character of the injury or disease, the length of time taken to perform the operation, and like matters would justify the jury in not finding the exact amount stated by the witness. All the facts and circumstances, together with the opinion, should be placed before the jurors, who must be permitted to exercise a judgment founded on the common knowledge of mankind. Experts may give their opinions, but they may not usurp the functions of the jury.

Liability of Corporations Undertaking to Furnish Employees Medical Attention—When Actions Are Barred

(Kain vs. Arizona Copper Co., Limited (Ariz.), 133 Pac. R. 412)

The Supreme Court of Arizona says that the plaintiff's action was not one for personal injury, or for malpractice by the mining company, but for breach of an alleged contract by which the mining company, in consideration of the plaintiff's paying it $1.80 a month, was, in case of sickness or injury, to furnish him proper hospital accommodations and the services of skilled and competent physicians and surgeons, etc. It was therefore error to hold that his action was one for personal injuries, barred by the one-year statute of limitations of Arizona. If the contract was verbal, the right to sue for a breach of it was limited to three years from its accrual under the statute, or, if the contract was in writing, the action could be commenced at any time within four years after the cause of action accrued.

It seems to be the conceded law by practically all the authorities that in cases of breach of contract the statute of limitations begins to run against the right of the person damaged to recover from the time of the breach, and not from the time actual damages are sustained in consequence thereof.

The mining company agreed to furnish the plaintiff, in case of sickness or injury, certain kind of service—good service, skilled service—and when it presented inferior and inefficient service the terms of the contract were violated and the statute began to run. The wrong done the plaintiff was not so much the incorrect diagnosis of his injuries but the furnishing of incompetent and unskilled physicians and surgeons from which the wrong diagnosis may have been the result. He contracted for a superior quality of skill and knowledge, but when he called for it he was given incompetency. That was certainly the injury from which all subsequent damages followed.

Under the contract, however, it was not enough to furnish skilled and competent physicians and surgeons. The contract contemplated and the law implied that the injury of the plaintiff should be diagnosed with skill and that it should be competently treated thereafter. The charge was incompetency of the surgeons, incorrect diagnosis, and negligent, incompetent, and careless treatment. The court may assume that, if the surgeons had possessed necessary knowledge and skill, the diagnosis and treatment would have been proper. If that be true, then the chief primal wrong consisted in placing over the plaintiff unskilled and incompetent physicians and surgeons. It might present a different question, however, if the physicians and surgeons had been skilled and competent and the injury consisted in unskilful, incompetent, and negligent treatment of the patient. In the latter case, although the court does not so decide, it is possible the statute would not begin to run until the patient was discharged.

Railway and mining companies that establish hospitals for profit and gain occupy the position of ordinary physicians and surgeons, and are bound by the same rules. If they undertake to furnish treatment, not as a charity, they stand in no different light from the ordinary physician.

Physician Not Given Rights by Orders, Nor Entitled to Challenge Choice of Another

(Sheets vs. Coast Coal Co. (Wash.), 133 Pac. R. 433)

The Supreme Court of Washington affirms a judgment for the defendant in this action wherein the plaintiff, a practicing physician, sought recovery from the defendant coal company on a number of orders signed by its employees, reading: "Coast Coal Co. You are hereby authorized to deduct $1 per month from my monthly pay, to pay for the services of Dr. Sheets as mine doctor." The court holds that these orders were, in substance, bills of exchange, and that the only manner in which the coal company could bind itself to pay them, under the provisions of the Washington statute, was by an acceptance in writing.

Assuming, however, the plaintiff to be entitled to be heard on the question as to whether he or a Dr. Douglas was the duly chosen physician of the employees, the court was met with the fact that, at an election held for that purpose, which manifestly was fairly conducted, and at which all of the employees were entitled to vote, whether members of the union or not, and where nearly all of them did vote, Dr. Douglas received a clear majority of such votes over the plaintiff, in pursuance of which election the contract was entered into between the union and Dr. Douglas for a period of one year, which entitled all of the employees, whether

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union members or not, to his services. Some argument was indulged in touching the authority of the union to enter into this contract with Dr. Douglas. But the court thinks that there was sufficient evidence in the record, especially as against the claims of the plaintiff, to warrant the conclusion that Dr. Douglas was employed by the union at the instance of the coal company, and thereby became the duly chosen mine physician for the benefit of all the employees. The orders on which the plaintiff rested were obtained from a number of employees during a period of about a month following the election.

The court thinks that the plaintiff, having failed to make sufficient showing entitling him to recover on the theory of his complaint, had no standing to question the binding force of the choosing of Dr. Douglas by the election as the mine physician. There was no question but that the $1 per month was retained from the wages of each of the employees, for the purpose of paying a mine physician, by consent of all the employees and in pursuance of the custom obtaining there, and, the physician having been fairly chosen and contracted with for the service to be rendered, the plaintiff could not defeat the validity of such choosing by the method he invoked. It was plain that the coal company did not collect any of the funds by authority of these orders, but by common consent of all of the employees who so paid $1 each monthly and in pursuance of the prevailing custom. No employee was obliged to pay—in fact some did not do so—but as to all who did so voluntarily pay, the plaintiff was in no position to challenge the method adopted by the coal company and the union for choosing a physician.

Validity of Board of Health Regulations as to Shipments of Manure

(Kinsey vs. Board of Health of Lexington (Mass.), 102 N. E. R. 352)

The Supreme Judicial Court of Massachusetts says that when a board of health seeks by a suit in equity to enforce its rules and regulations it puts in issue, at the election of the defendant, their validity and reasonableness, and if the defendant in any given case choses to accept the issue thus tendered, he has an undoubted right to do so, and to have the matter determined by the court.

But the court can see no ground on which it can be held that the regulations of a board of health are void which require manure brought into town by railroad to be unloaded at a certain place and to be unloaded within seventy-two hours after the consignees have received notice of its arrival, and which provide that no car-load of manure shall remain or stand on any track or siding of the railroad except at a named place, for more than twelve hours. Such regulations relate to matters into which it is made the duty of the board of health to inquire and concerning which it is expressly authorized to make regulations.

Whether manure, particularly stable manure, is capable of containing or conveying infection or contagion or of creating sickness is for the board of health to determine, subject only to such considerations as may arise in an inquiry, in proceedings where the question is properly raised, into the reasonableness of the regulations that have been adopted.

There can be no question that the regulations in question are such as it is within the constitutional power of the legislature by a general authority to empower local boards of health to make if they are found to be reasonable and just. It is not material that it will be more inconvenient and expensive for the consignee to unload manure at the designated place than it was at the places where he had unloaded it theretofore, and that his business as a market gardener would be interfered with to that extent. All property and business is subject to such reasonable restraint and regulation as, within constitutional limits, the legislature may deem necessary and expedient for the public health and safety. Whether the regulations would apply to manure brought into town by the railroad and left standing in cars on a siding on the consignee's own land it was not necessary in this case to consider.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Tropical Diseases and Preventive Medicine, New Orleans

November, 1, No. 5, pp. 353-424

1 Classification of Amebae, with Special Reference to Parasitic Species. C. F. Craig, U. S. Army.
2 Bacterial Pollution of Mississippi River Water by Sewage Effluent from City of New Orleans. H. E. Lemoine, New Orleans.
3 Malta Fever in Louisiana. C. Wellman, A. Eustis and S. S. Schochet, New Orleans.
4 Case of Dhobie Itch (Tinea Cruris), and Cultivation of Causal Fungus (Epidermophyton Rubrum). W. L. Culpepper, New Orleans.
5 Pinta. J. E. Smith, Bocas del Toro, Panama.
6 Mounting of Mosquito Larvae. W. V. King, New Orleans.

Journal of Biological Chemistry, Baltimore

December, XVI, No. 3, pp. 331-436

7 Bacterial and Enzymic Changes in Milk and Cream in 0 C. M. E. Pennington, J. S. Hepburn, E. Q. St. John, E. Witmer, M. O. Stafford and J. I. Burrell, Baltimore.
8 Reaction of Some Purin, Pyrimidin and Hydantoin Derivatives with Uric Acid and Phenol Reagents of Folin and Denis. H. B. Lewis and B. H. Nicolet, New Haven, Conn.
9 Formation of Glucose from Propionic Acid in Diabetes Mellitus. I. Greenwald, New York.
10 Action of Radium Emanation on Lipase. E. K. Marshall and L. G. Rowntree, Baltimore.
11 Determination of Amino-Acid Nitrogen in Urine. S. R. Benedict and J. R. Murlin, New York.
12 Tolerance Shown by Elasmobranch Fish toward Certain Nephrotoxic Agents. W. Denis, Woods Hole, Mass.
13 *Urea Formation in Liver. C. H. Fiske and H. T. Karsner, Boston.
14 Saturated Fatty Acid of Kephalin. P. A. Levene and C. J. West, New York.
15 *Influence of Butter-Fat on Growth. T. B. Osborne and L. B. Mendel, New Haven, Conn.
16 Metabolism Studies on Cold-Blooded Animals: Blood and Urine of Fish. W. Denis, Woods Hole, Mass.

13. Urea Formation in Liver.—According to Fiske and Karsner the surviving liver is capable of destroying ammonia perfused through it in the form of ammonium carbonate, and of converting it partially into urea. The entire amount of ammonia changed, however, does not have this fate. How much, if any, of it undergoes synthesis to amino-acids has not been determined. The authors doubt whether the binding of ammonia as such by the liver cells is of much significance in the protective influence of the organ, as indicated by the lack of variation in total non-protein nitrogen content of the fluid during the experiment. The perfusion of the liver of the cat or the rabbit with homologous defibrinated blood containing as much as 44 mg. of nitrogen as glycocoll per 100 c.c. did not lead to any increase in the amount of urea in the fluid used. The formation of urea from amino-acids by the liver was not conclusively demonstrated. There is no incontestable ground for the assumption that the liver is a special site for such a process. The only amino-acid used by the authors has been glycocoll.

15. Influence of Butter-Fat on Growth.—The outcome of the authors' experiments indicates that the growth-promoting substance of the milk is to be found in the butter-fat fraction thereof. The influence of heating and other processes involved in the preparation of milk for food were also incidentally investigated. These studies, though far from completed, have given no evidence, in so far as nutrient efficiency is concerned, of a damage to the centrifugated milk by vigorous sterilization. By numerous experiments they have shown that mature rats can be maintained on "protein-free milk" diets for more than a year, and that young rats on similar diets containing proteins inadequate for growth can be maintained nearly as long. Such foods consequently supply all that is essential for maintenance alone. Since growth ceases on these foods after a comparatively short time, and is at once resumed and continued throughout the entire period of normal growth when a part of the lard is replaced by butter-fat, the authors believe that it is almost certain that butter-fat contains something essential for growth in addition to what may be required for maintenance. This recovery and renewed growth

must be attributed to something which distinguishes butter from the ordinary fats, for not only do lard and olive oil lack this growth-promoting power, but young rats grow on "protein-free milk" foods when all of the lard is replaced by carbohydrate and no ether-soluble substances are present in the food.

It thus appears improbable that glycerids of the fatty acids ordinarily present in foods are responsible for the promotion of the growth observed when butter-fat replaces lard in the diet of rats which have ceased to grow. Lecithin and other phosphorus or nitrogen-containing substances are excluded by the absence of phosphorus and nitrogen from butter-fat; and cholesterol by the fact that even more of this substance has been obtained from lard than from butter. So far as Osborne and Mendel's experience has shown, the addition of butter-fat to our natural "protein-free milk" foods gives them an efficiency quite comparable with that of milk-food in promoting recovery and the completion of growth.

The exact chemical differences between the adequate butter-fat and the inadequate lard (which determine success and failure, respectively, in the food-mixtures employed) are far from being satisfactorily known. Chemical examination of the butter-fat indicates that the effective component is not a phosphatid or any inorganic substance, inasmuch as nitrogen, phosphorus and ash are lacking in the product employed. It is suggestive to note that in the case of the lard we are dealing essentially with a fat-mixture deposited in storage depots of the animal organism; in the other, the butter-fat represents the product of metabolic activity and synthesis on the part of the cells of the mammary gland. What, if anything, this distinction between cellular product and reserve fat may mean physiologically, remains to be investigated. Butter-fat has shown a further interesting nutritive superiority over lard. At certain periods of the year, particularly in summer months, the authors have frequently failed to secure satisfactory growth on the dietaries which proved adequate during the usual period of sixty to one hundred days at other seasons. Occasionally young rats in the stock colony have exhibited a similar "epidemic" of poor growth at the same season. The failures are, however, not common to rats fed on the milk-food; and Osborne and Mendel have lately observed that the seasonal failure is also averted by the addition of butter-fat to the usual "protein-free milk" food-mixtures. Again, another type of nutritive deficiency exemplified in a form of infectious eye disease prevalent in animals inappropriately fed is speedily alleviated by the introduction of butter-fat into the experimental rations. On the other hand, no amount of butter-fat will induce growth on certain dietaries in which the proportions and nature of the inorganic salts are inappropriate or the quantity and character of the protein is inadequate. Egg yolk-fat appears to behave like butter-fat; some other oils have thus far proved no more efficient than lard. Such considerations make it evident that the comparative value of the natural fats employed in nutrition must be determined, as well as the individual rôle of the different proteins, carbohydrates and mineral nutrients.

Journal of Experimental Medicine, New York

December, XVIII, No. 6, pp. 661-755

17 *Intraperitoneal Lysis of Tubercle Bacilli. W. H. Manwaring and J. Bronfenbrenner, New York.
18 *Further Experimental Studies in Tetany. W. G. MacCallum and K. M. Vogel, New York.
19 *Characters of Third Transplantable Chicken Tumor Due to Filterable Cause. P. Rous and L. B. Lange, New York.
20 Relation of Spleen to Blood Destruction and Regeneration and to Hemolytic Jaundice. E. B. Krumbhaar, J. H. Musser and R. M. Pearce, Philadelphia.
21 *Production of Experimental Nephritis by Repeated Proteid Intoxication. W. T. Longcope, New York.
22 Relation of Auricular Activity following Faradization of Dog's Auricle to Abnormal Auricular Activity in Man. G. C. Robinson, New York.
23 Effect of Morphin on Mechanism of Dog's Heart after Removal of One Vagus Nerve. A. E. Cohn, New York.
24 Predominant Influence of Left Vagus Nerve on Conduction between Auricles and Ventricles in Dog. A. E. Cohn and T. Lewis, New York.

17. **Intraperitoneal Lysis of Tubercle Bacilli.**—Manwaring and Bronfenbrenner found that tubercle bacilli injected into the peritoneal cavities of tuberculous guinea-pigs, rats, rabbits, dogs and monkeys rapidly disappear from the peritoneal fluids, while persisting in the peritoneal fluids of normal control animals. This disappearance they regard as being in part due to an adhesion of the injected bacilli to the peritoneal leukocytes and a fixation of the leukocytes on the omentum. The injected tubercle bacilli can be recovered quantitatively from the peritoneal cavities of normal guinea-pigs from one and one-half to two hours after the injection, while from tuberculous guinea-pigs only 65 per cent. of the bacilli can be recovered at this time. Isolated peritoneal tissues from tuberculous guinea-pigs have the power of destroying tubercle bacilli *in vitro*. A second factor reducing the number of tubercle bacilli free in the peritoneal fluid is therefore an actual lysis of the bacilli. The intraperitoneal lysis is not due solely to substances present in the circulating fluids, since the phenomenon cannot be produced by these fluids *in vitro*, and since a lytic power cannot be passively conferred even by a direct transfusion of blood from tuberculous to normal animals. The intraperitoneal lysis is apparently due to specific changes in the fixed peritoneal cells of the tuberculous animals.

18. **Tetany.**—It has been the author's aim to determine in what particular the blood is altered during tetany so that it can produce hyperexcitability of the motor nerves. As a working hypothesis it has been assumed that (1) there may be a lack of calcium in the blood and tissues; (2) there may be a circulating poison which like an oxalate could render inactive the circulating calcium, and (3) there may be a substance in circulation vaguely resembling strychnin in its action on the nervous system and directly causing the hyperexcitability. The authors do not attempt to decide which, if any, of these explanations is the true one, but certain experimental results are brought forward. If tetany blood be used to perfuse a normal leg the excitability of the nerves rises to a characteristically high level and the addition of parathyroid extract to the blood has little or no effect in lowering this excitability. Parathyroid extract whether from the ox or the dog fails when injected into the circulation of an animal in tetany to reduce the excitability of the nerves markedly or permanently, although it seems to affect the more sensitive ganglion cells, thus cutting off excessive impulses to the periphery. Although the nerves remain hyperexcitable, tetany is usually much diminished or abolished entirely.

This seems to be analogous to the action of ether or any other anesthetic which may inhibit the activities of the ganglion cells, although it leaves the nerves excitable and able to conduct impulses. An animal in tetany relaxes instantly on being given ether although the excitability of the nerves to electric currents is little changed. Bleeding followed by the replacement of the blood with an indifferent solution free from calcium stops tetany and lowers the excitability of the nerves. Probably this cannot be ascribed to the removal of a circulating poison, but rather to a general disturbance of the nutrition of the nervous system. Oxalate-like substances introduced into the circulation rapidly, and for a short time only, may kill the animal, but they seem to produce no change in the excitability of the nerves. If the solution is injected very slowly and over a long period the protective action of the body seems to be overcome and the excitability of the nerves rises to high levels. This seems to resemble somewhat the latent period after the destruction of the parathyroid before tetany begins. Direct analysis of the blood shows that as compared with the normal, the blood of an animal in tetany is very poor in calcium. Administration of parathyroid extract does not increase this calcium content. On the contrary, if the extirpation of the parathyroids has been incomplete so that tetany does not appear, the calcium content of the blood is that of the normal animal. Even yet, therefore, in spite of efforts to shake it, the theory that tetany is closely dependent on a disturbance of the calcium content of the blood is supported by stronger evidence than any other idea, but much remains to be done before a clear conception of the process is reached.

19. **Chicken Tumor Due to Filterable Cause.**—A spontaneous chicken sarcoma, peculiarly fissured by blood sinuses and with

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a tendency to intracanalicular extension into them, has been transplanted by Rous and Lange and studied in eight successive groups of fowls. Histologically the growth is a characteristic neoplasm, while in its transfer to new hosts a real transplantation is obviously involved. The development of the first few series of transplantation tumors was very slow. They exhibited the histologic structure of the original growth and had the same tendency to metastasize to the skeletal muscles. Recently the tumor has grown more rapidly and in a higher percentage of hosts. With this has come a simplification of structure to that of a pure, spindle-celled sarcoma. Fowls of an alien variety (Plymouth Rock) form quite as good hosts for the tumor as those of the sort (Brown Leghorn) in which it was originally found. It has grown in pigeons, rats or mice. The question of the cause of tumor is not taken up. It has been found to be due to an agent which will pass through Berkefeld filters. The growth is quite distinct in its characters from the other two transplantable neoplasms of the fowl (a spindle-celled sarcoma, an osteochondrosarcoma) which have such a cause. No growth like it has been observed among the forty-three spontaneous tumors of the fowl that have come under the authors' observation.

21. **Production of Experimental Nephritis.**—The repeated injection of small doses of horse serum and egg-white in dogs, cats, rabbits and guinea-pigs that have been sensitized to these proteins, has been found by Longcope to cause injury to the cells of various organs and tissues with resulting inflammatory reactions. The changes are especially marked after intraperitoneal injections in the peritoneum and after intravenous injections in the livers of rabbits and cats, and in the myocardium and kidneys of all groups of animals. In dogs and rabbits, especially, there develops a well marked nephritis characterized by degeneration and necrosis of the epithelium of the loops of Henle, of the collecting tubules, and less frequently of the convoluted tubules. This is accompanied by an extensive small round-cell infiltration of the interstitial tissue and later the formation of connective tissue. Together with these changes there are acute and chronic alterations in the glomeruli of all groups of animals. Egg-white in large doses is itself injurious to the kidney of animals, but this slight primary toxicity is probably greatly enhanced through previous sensitization of the animal.

Wisconsin Medical Journal, Milwaukee

November, XII, No. 6, pp. 171-210

25 •Intraspinous Medication in Paresis and Tabes. W. F. Lorenz, Mendota.
26 •Effects of Athletic Sports on Heart. C. R. Bardeen, Madison.
27 Traumatic Neurasthenia and Malingering. C. H. Lemon, Milwaukee.
28 Fracture of Skull. L. M. Warfield, Milwaukee.
29 Practically Bloodless Tonsillectomy. H. B. Hitz, Milwaukee.

25 and 26.—Abstracted in THE JOURNAL, November 1, pp. 1656 and 1657.

FOREIGN

Titles marked with an asterisk (•) are abstracted below. Single case reports and trials of new drugs are usually omitted.

Journal of Pathology and Bacteriology, London

October, XVIII, No. 2, pp. 149-305

1 Studies in Paleopathology in Egypt. M. A. Ruffer.
2 •Lipoid Anaphylaxis. F. P. Wilson.
3 •Cytology and Bacteriology of Condensed Milks. F. W. Andrewes.
4 Lipoids of Ancient Egyptian Brains. W. Muir.
5 Preparation and Saponification of Cholesteryl Esters. W. Muir.
6 Comparative Anatomy of Bulbus Cordis, with Special Reference to Abnormal Positions of Great Vessels in Human Heart. J. I. Robertson.
7 Four Cases of Congenital Deformity of Heart due to Anomalous Mechanical Influences in Malformed Fetus. J. I. Robertson.
8 Summary of Blood-Parasites of British Sea-Fish. H. Henry.
9 Intracorpuscular Parasite in Blood of Cottus Bubalis and Cottus Scorpius. H. Henry.
10 New Hemosporidian from Scomber Scomber, the Common Mackerel. H. Henry.
11 Hemogregarine and Leukocytozoon from Gadus Eglefinus. H. Henry.
12 Granule Shedding of Hemogregarina Simondi. H. Henry.
13 Consideration of Infective Granule in Life-History of Protist Organisms. H. Henry.
14 •Arterial Lesions Associated with Rheumatic Fever. O. Klotz.
15 Estimation of Complement and Amboceptor. J. O. W. Barratt.
16 •Hepatic Insufficiency as Estimated from Nitrogen Partition of Urine. W. MacAdam.

2. **Lipoid Anaphylaxis.**—Attempts were made by Wilson to sensitize guinea-pigs to lipoids of varying chemical and biochemical properties extracted from rabbits' livers. The results were negative. Lipoids extracted from egg-yolk in a similar manner, and which differed considerably from the liver lipoids, also failed to produce anaphylaxis. Some doubtful evidence was obtained that a pure lipoid from one source might sensitize an animal to a lipoid of different origin. Dried liver substance and dried egg-yolk do not sensitize to lipoids derived from these substances. Lipoids from yolk of egg sensitize animals to dried liver substance, but liver lipoids will not sensitize to dried egg-yolk. Pure lipoids from any substance will sensitize an animal to a crude extract of the substance, but repeated injections of pure lipoids do not produce anaphylaxis.

3. **Cytology of Condensed Milks.**—Unsweetened liquid preserved milks have no bacteriology, for, Andrewes says, if they were not sterile they would not keep. The case is very different with sweetened condensed milks. In the examination, by culture, of forty-five samples, forty-three of which were machine-skimmed products, Andrewes found living bacteria in every one. Even a good and popular brand of condensed milk yielded a moderate number of colonies of *Staphylococcus albus*, but of the tins examined, forty-three were cheap machine-skimmed milks. Thirty one samples yielded almost pure cultures of staphylococci, among which *Staphylococcus pyogenes aureus* was conspicuous and often predominant. These samples were almost all from a single foreign country, emanating in tins bearing the labels of three different brands, from one single factory. Andrewes' opinion is that the presence of *Staphylococcus pyogenes aureus* in large numbers in a condensed milk is objectionable and should probably constitute a ground for condemnation, even though the potential harmfulness of such a product is unproven. Efficient pasteurization, before condensation and before the addition of sugar, should prevent the presence of such organisms in the final product, however difficult it may be to destroy them afterward, for in the majority of condensed milks they are absent or but scantily present.

14. **Arterial Lesions in Rheumatic Fever.**—Klotz urges that greater attention be given to the various types of acute aneurysms and their relations to acute rheumatic fever; and further, that the almost constant presence of some inflammatory reaction in the ascending limb of the aorta be recognized as an associated condition in this disease.

16. **Hepatic Insufficiency.**—The estimation of any one element of the nitrogen partition of the urine, Macadam believes, is useless as a guide to hepatic efficiency; their interrelationships have to be considered. After the injection of hydrazin sulphate there is an increased excretion of total nitrogen, as found also in phosphorus poisoning. It is probably due to the disturbance of glycogenic function with the subsequent direct or indirect disintegration of the muscle protein. The increase in amino-acid nitrogen, both absolutely and relatively to the total nitrogen, is the most constant feature of the urinary nitrogen partition during the hepatic disturbance produced by hydrazin. Further, this increase is invariably the earliest abnormality to be detected. After hydrazin injection the urea percentage of the total nitrogen increases, and the ammonia diminishes, slightly in sublethal, markedly in lethal, experiments. Neither acetone nor diacetic acid was detected in the urine during the course of any of the experiments. The excretion of creatinin is found to be practically constant, while there is a large excretion of creatin, which appears to be dependent on impaired glycogenic function exerting its influence on the muscle metabolism, rather than on liver inefficiency, leading to a decrease in the conversion of creatin to creatinin. This seems to be indicated by the increased catabolism of "muscle flesh" as calculated from the output of total creatinin.

Archives des Maladies de l'App. Digestif, Paris

VII, No. 9, pp. 481-540

17 *Hemorrhagic Infarct of the Pancreas from Pylephlebitis. E. Chabrol.
18 Diagnosis and Treatment of Gastric Ulcer. K. Petren.

No. 10, pp. 541-600

19 *Intestinal Disturbances Consecutive to Gastro-Enterostomy. A. Mathieu and R. Savignac.

17. Hemorrhagic Infarct of the Pancreas.—Chabrol presents evidence to show that infection by way of the blood or from the intestines is always a factor in splenophlebitis with hematemesis, infarct of the intestine from mesenteric thrombosis, and infarct of the pancreas from thrombophlebitis.

19. Intestinal Disturbances from Abnormally Rapid Evacuation of the Stomach.—Mathieu and Savignac review eleven cases in which more or less serious bowel trouble followed a gastro-enterostomy; the stomach content was passed along through the new outlet before there had been time for the gastric juice to act on it properly. In some cases there was intermittent or continuous diarrhea, sometimes extremely rebellious; in others there were discomfort and pain after meals, resembling the syndrome with gastroptosis. Roentgenoscopy will exclude a fistula between the stomach and the colon, incomplete stenosis of the small intestine and ulcer in the jejunum, which the symptoms suggest. The surgeon should aim to make the gastro-enterostomy continent so that it will retain the stomach content for the normal period. When this has not been accomplished, the patient should restrict his diet to bland foods leaving little waste, and the meals should be small. The soft diet should be supplemented by some preparation of opium, and by hydrochloric acid and gastric juice. Reclining during the period of discomfort, and wearing a girdle to help support the sagging organs are also useful when the intestine becomes distended and heavy and drags on the abdominal plexuses.

Lyon Médical, Lyons

November 9, XLV, No. 45, pp. 749-780

20 *Amyotrophic Tabes. Drey and Malespine.

20. Amyotrophic Tabes.—This article discusses a form of tabes in which the chief symptom is a comparatively rapid and progressive atrophy of the muscles due to an extension of the pathologic process to the anterior roots. The picture resembles that of polyneuritis more than that of tabes. The classic symptoms of tabes have to be carefully looked for in differential diagnosis.

Presse Médicale, Paris

November 15, XX, No. 93, pp. 929-940

21 *Pathogenesis of Cholelithiasis. A. Chauffard.
22 Vaccination against Typhoid at Tunis. C. Nicolle and others.

November 19, No. 94, pp. 941-948

23 Nodose Erythema with Tubercle Bacilli in the Blood-Stream. L. Landouzy.
24 Hernia plus Mesenteric Cyst. P. Lecène.

21. Pathogenesis of Gall-Stones.—Chauffard comments on recent research by Grigaut, published in his thesis last summer under the title the "Cycle of Cholesterinemia." The work was done in Chauffard's laboratory and apparently demonstrates that when there is deficiency in the production of bile salts, the cholesterin is not held properly in solution and hence it is retained in the serum. The excess of cholesterin in the blood causes part to drop out at points favoring sedimentation, especially in the gall-bladder. The primal trouble is thus an insufficiency on the part of the liver. Whatever the cause of this liver disturbance, whether it is due to over-eating, too sedentary life, obesity, pregnancy or inherited taint, treatment should aim to restore normal functioning or supplement by administration of bile salts the lacking elements in the bile.

Berliner klinische Wochenschrift

November 17, L, No. 46, pp. 2121-2168

25 *The Red Bone Marrow in the Femur. (Die Verbreitung des rothen Knochenmarkes im Oberschenkel des Menschen.) E. Hedinger.
26 *Alimentary Fat in the Myocardium. C. Wegelin.
27 Blood-Findings in Lymphogranulomatosis; Nine Cases. O. Steiger.
28 Some Recent Research on the Physiology of Digestion and Metabolism. (Darmgärungen; Energieverbrauch bei Mästung, Wachstum und Eibildung.) N. Zuntz.
29 *Diabetic Coma. L. Blum.
30 *Diathermia in Leprosy. P. Unna.
31 *Intussusception in Infants. (Ueber die sogen. Invaginatio ileocoecalis.) F. Lotsch.
32 Importance for Psychiatry of Jodl's System of Psychology. H. Marcuse.

25. The Red Bone Marrow in the Femur.—Hedinger has examined over a thousand cadavers to determine the distribution of the red marrow in the bones, especially in the femur, and has recorded data in five hundred, including forty-four cases of sudden death from suicide or accident. His findings conflict with the statements in the text-books.

26. Alimentary Fat in the Myocardium.—Wegelin found fat in the heart muscle in a previously robust insane young man who died in an accident, and also in an infant cadaver. The fat in the myocardium in these cases must be accepted as a physiologic phenomenon. This assumption is corroborated by the findings in his extensive research on white rats and other animals. They all confirm the fact that when fat is taken in the diet there are liable to be deposits in the myocardium without signs of degeneration.

29. Diabetic Coma.—Blum discusses the three forms of coma, the cardiovascular, the form with dyspnea and the form in which the dyspnea type merges into the cardiovascular type. The blood-pressure is not always subnormal at first. In regard to the ocular tension, he says that the loss of water is not sufficient alone to explain the reduction; the salts must be involved also. Under treatment with large doses of alkali the ocular tension is liable to return to normal. This reduction in ocular tension may occur outside of coma, as in a recent case of acute fatal gastro-intestinal disease. The ocular tension was 4 or 5 mm. fourteen hours before death, but there was no tendency to coma. The loss of water in the profuse diarrhea was undoubtedly responsible for the change in the ocular tension.

Blum's experience has been that stimulants and epinephrin are unable to arrest the progressive weakness of the circulation in coma. This shows that they do not influence the cause of the vascular trouble. Improvement follows only when the acid becomes neutralized by sufficient intake of an alkali. He gives sodium bicarbonate or citrate, 5 or 10 gm. by the mouth, every half hour until the urine gives an alkaline reaction. The alkali is taken in carbonated water or wine or in capsules which pass through the stomach unmodified. In case of a tendency to diarrhea, he adds equal parts calcium carbonate to the sodium bicarbonate or citrate, up to a total of 250 gm. of the mixture in twenty-four hours. He has never witnessed any benefit from the alkali given by the rectum. Untoward by-effects are liable to follow intravenous infusion of the alkali unless it is given in the form of solutions of the sesquicarbonate, obtained by boiling sodium bicarbonate. The concentration should not go above that corresponding to a 6 per cent. solution of sodium bicarbonate. The infusion should not be repeated unless profuse diuresis guarantees that part of the sodium salt has been eliminated. By heeding these factors, intravenous infusion is practicable. He does not think it advisable to keep up the alkali indefinitely, on account of injury to the stomach. When coma is once installed, a purge is of little use, but great improvement is liable to follow a purge in the precoma stage.

30. Diathermia in the Nervous Form of Leprosy.—Unna has applied in seven cases this method for inducing high temperatures in the depths of the tissues, and states that it has a remarkable effect in arresting the pains at once. With continued applications permanent results can be attained, deep infiltrations being absorbed. It also loosens up the tissues, rendering them more amenable to general measures.

31. Intussusception in Infants.—Lotsch reports the recovery of two infants out of twelve operated on for ileocecal invagination. In only five cases was the interval less than twelve hours before the operation and the two children who recovered were in this group. In six additional cases of invagination the trouble was in the small intestine and the children were

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older; this group includes also three adults. Attempts at manual reduction and reduction by high injections have little prospect of success. No time should be wasted on them, he insists, as the only chance for recovery is in an early operation.

Medizinische Klinik, Berlin

November 16, IX, No. 46, pp. 1879-1920

33 Chemotherapy of Tuberculosis. C. Bruck.
34 *Diagnosis and Treatment of Hematuria. E. Portner.
35 The Food of the Japanese. K. Suto.
36 *Operative Treatment of Detachment of Retina. (Netzhautablösung.) Elschnig.
37 Combined Tincture of Iodin and Ichthyol Treatment of Furunculosis. F. Berger.
38 *Physiology and Treatment of Diseased Tonsils. H. Röder.
39 *Perforated Ear Drum May Be Responsible for Sudden Death in Water. A. Güttich.
40 Possible Adaptation to Function of Severely Crippled Limb. (Beitrag zur Gebrauchsfähigkeit schwer geschädigter Glieder bei Nicht Unfallverletzten.) A. Weinert.
41 Physical Measures in Treatment of Skin Diseases. E. Saalfeld.
42 Etiology of Molluscum Contagiosum. B. Lipschütz.
43 Technic for the Wassermann Test. (Zur Frage des verfeinerten Wassermann mit bes. Berücksichtigung der sogen. Paradoxen Sera.) F. Graetz. Commenced in No. 45.

34. Hematuria.—Portner insists that the cystoscope is indispensable in examining a case of hematuria, and there should be no delay in applying it. The only exceptions are with acute gonorrheal cystitis and hypertrophy of the prostate. He discusses the interpretation of the cystoscope findings, warning that both kidneys may be involved, and also that the discoloration of the urine may be due to hemoglobinuria. To exclude chronic nephritis, the urine should be examined after exercise and during bed-rest. If no cause for the hematuria can be discovered, the bleeding and painful kidney should be opened up in six or eight weeks at latest, as the trouble may be a tumor. Bleeding from instrumental injury generally stops of itself but infection should be warded off with hexamethylenamin and copious drinking. If there is much hemorrhage, a retention catheter may help to arrest it. Slight bleeding from the posterior urethra generally occurs with a few drops of pure blood at the end of micturition; gonorrhea and tuberculosis of the bladder may show hematuria of this kind. With profuse hemorrhage in the posterior urethra the blood runs into the bladder and mixes with the urine. Blood in the sperma is usually a sign of gonorrheal inflammation of the seminal vesicles, but it may be an early sign of a tuberculous process or of cancer of the prostate. If the prostate is found enlarged in a case of hematuria without pain, the prostate is generally responsible for it, and if the hemorrhage recurs repeatedly, malignant disease may be assumed unless the cystoscope reveals some cause in the bladder. The hemorrhage with calculi in bladder or kidney is harmless unless infection is superposed, but the slightest suspicion of cancer requires operative treatment. It is a comparatively recent discovery that hemorrhage may occur with chronic nephritis alone. The operation undertaken to remove the assumed calculus or tumor cured the tendency to hemorrhage and taught that nephrectomy is the only means to remove danger from this source. Hematuria with an incipient tuberculous process in the kidney is like hemoptysis in early pulmonary tuberculosis, important and useful as it permits treatment in time to be effectual.

36. Operative Treatment of Detachment of the Retina.—Elschnig states that he has punctured and injected 1 c.c. of the patient's own serum or salt solution in twenty cases; on both eyes in two of them. By aspirating out part of the fluid that has accumulated beneath the retina and, practically simultaneously through another cannula, injecting fluid in front of the retina to push it back into its normal place, approximately normal conditions can be restored. Seven of the eyes were much improved but the condition was aggravated in ten. In one case a mycotic process developed, finally destroying both eyes. He has never had a complete cure, being less fortunate in this than Birch-Hirschfeld. But the method may arrest the trouble and save partial vision at least, when under less vigorous measures the eye is inevitably doomed.

38. Pathologic Importance of the Tonsils.—Röder declares that if the physician is not content with a cursory inspection of the apparently intact tonsils, but insists on lifting the anterior palatine arch and examining all the recesses, and squeezes the tonsils, drawn out by a suction apparatus, he will become convinced that the lymphatic vessels at the entrance to the throat take a leading part in the functioning of the organism as a whole. Not only joint troubles but a number of other local and general disturbances improve after a housecleaning of the tonsils. This not only clears away disease-breeding detritus, etc., but it starts up a healthy circulation of lymph through the parts. Fresh lymph pours into the tonsils, and the data presented testify that a strong current of lymph setting into the tonsils is an important element for health. When this current becomes obstructed by detritus, etc., we have trouble at once. In one case of incipient measles he applied the suction apparatus to the apparently sound tonsils and aspirated considerable pus; in a few minutes the swelling of the face and eyes began to go down. Cleansing out the tonsils may cure a persisting bad odor of the breath. Under normal conditions the act of swallowing squeezes out the secretions and detritus in the tonsils; the bad odor is thus most evident fasting.

This conception of the important part played by the tonsils necessarily forbids routine tonsillectomy. Treatment must aim to cure the tendency to chronic inflammation and restore the functioning of the tonsils. He applies the tonsil suction apparatus with moist cotton in the spoon blades. Local applications of tincture of iodin, etc., are irritating and do no good. The general circulation of the lymph is stimulated with brine baths, inunctions and internal administration of cod liver oil, and iodin or 1 per thousand mercuric cyanid by the drop, every hour or two. He has never found it necessary to resort to the knife, although this might be indicated if the tonsil had hardened so that the plugs of pus could not be forced out. Röthlisberger's massage sometimes proves useful, especially when the effect is enhanced by pressure from without on the massaging finger. In conclusion Röder reiterates that by this means the physician's own knowledge and skill relieve the patient of his pains and disease without the necessity for drugs or for an operating specialist or chemicals.

39. Sudden Death in Bathing.—Güttich describes the serious symptoms which follow irritation of the vestibular apparatus with cold water poured into an ear with perforated drum. Not only nystagmus but vertigo, vomiting and general collapse have been observed. Even with a sound membrane, these symptoms may develop if water at a temperature of 10 C. is used for the test. These facts amply explain many cases of sudden death in bathing. The water penetrates through the perforation, or the force of the water in diving, or a wave dashing against the ear may burst a weakened tympanic membrane. Passow has related cases of this kind. There may be a temperature irritation in the internal ear just from the coldness of the water alone, acting on the exterior of the body. The consequent irresistible vomiting or collapse under the water might easily cause death. A meal not long before renders the vomiting reflex easier to elicit. The reaction as a whole is liable to be proportional to the difference of temperature between the water and the air. Persons with perforated membrane should be warned against diving and bathing in too cold water; they should plug the ear with oiled cotton. The ears of a drowned person should be examined for perforation of the membrane.

Münchener medizinische Wochenschrift

November 18, LX, No. 46, pp. 2553-2600

44 Esophageal Cardiogram. (Registrierung des Druckes im rechten Vorhof und Wert des oesophagealen Kardiogramms für die Erklärung des Jugularvenenpulses.) A. Weber.
45 Experimental Production of Concrements. (Experimentell erzeugte Ablagerungen von Cholesterinestern und Anhäufungen von Xanthomazellen im subkutanen Bindegewebe des Kaninchens.) N. Anitschkow.
46 *Desiccated Antitoxin and Serums. (Vermeidung der Anaphylaxiegefahr durch eine neue Art der Serumeinverleibung—Injektionsfertiges Trockenserum.) W. Eichholz.
47 *Obliterating Arthritis. E. Veiel.
48 Practical Identity of Radium and Roentgen Rays. A. Pagenstecher.

49 *Epinephrin in Recurring Osteomalacia. H. v. Salis.
50 *Tonic Neck Reflexes in Man. R. Magnus and A. de Kleijn.
51 Rumination in Three Generations. (Ausserordentlicher Fall von menschlichem Wiederkauen.) v. Gulat-Wellenburg.
52 *Lymphoblast and Myeloblast Leukemia. G. Herxheimer. Commenced in No. 45.
53 *The High School for Physicians and Patients. XI. M. Nassauer.

46. Desiccated Antitoxin and Serums.—Eichholz states that experimental research has apparently demonstrated that a suspension of desiccated serum in olive oil seems to retain all the therapeutic possibilities unimpaired while the serum is absorbed so much more slowly and gradually that there does not seem to be any danger of anaphylaxis or serum sickness. The desiccated serum naturally cannot be used where speedy action is wanted, but it may be found useful in prophylaxis and in cases in which there are reasons for anticipating trouble from anaphylaxis.

47. Obliterating Arteritis.—Veiel reports two new cases similar to those published by Erb in which young men developed intermittent claudication after a crushing injury or long chilling or inflammation causing obliterating inflammation in the artery of the foot or leg. In one of his cases the claudication disturbances came on spasmodically even when the patient was at rest. There is nothing to suggest arteriosclerosis in either case, but the nervous system in all such cases seems to have been predisposed by abuse of tobacco.

49. Epinephrin Treatment of Recurring Osteomalacia.—Salis calls attention to the remarkable efficacy of a course of epinephrin, according to Bossi's principles and technic, in the case of a woman of 42 who had had osteomalacia develop during her various pregnancies and recur during the intervals, a martyrdom through sixteen years. None of the usual measures, including castration eleven years before, had given more than transient relief, but under the epinephrin she lost her pains and inability to walk and there was no further local tenderness, so that she is now clinically cured.

50. Neck Reflexes.—Magnus and de Kleijn have continued their study of the peculiar tonic reflexes in the limbs to be elicited by turning the head of decerebrized laboratory animals. The same reflexes can be elicited in patients with disease shutting off the brain, and they here report the case of a girl of 9, a total idiot, with no apparent perception of sound or light, blind, deaf and dumb. By turning the child's head over to the right side, the right arm and leg at once straighten out while the left arm and leg become flexed. Turning the head to the left, the left arm and leg stretch out straight while the right arm and leg become flexed. Drawing the child's head over so that the right ear is brought nearer to the shoulder, the right arm and leg relax, while the left arm and leg straighten out; the reverse occurs when the left ear is drawn down to the left shoulder. Lifting and lowering the head do not elicit any appreciable reflexes. The reflexes elicited are permanent, that is, the limbs stay in the position they assume in the reflex movement.

52. Leukemia Simulating Typhoid Lesions.—Herxheimer emphasizes that the leukocytes in leukemia are below par to such an extent that they are not able to defend against infections, and hence the leukemic are particularly subject to infectious processes. The gums, the throat, the nose, have often been the seat of infectious processes, and thirty-eight cases are on record in which the infectious processes were located in the intestines, the findings suggesting typhoid or paratyphoid ulceration. This was particularly evident in Herxheimer's three cases of myeloblast leukemia. One of the cases had been labeled typhoid until the blood-count disproved this. The intestinal findings were exactly those of typhoid, but all the tests for typhoid or paratyphoid bacilli proved negative. The ulcerations were in the ileum exclusively and they were evidently the work of the colon bacillus alone. In conclusion he reports a case of lymphatic leukemia on which became superposed a myeloblast leukemia. The mediastinal tumor, tumefaction of the pancreas and enlargement of the heart were evidently the work of the latter. The patient was a youth of 16 with chronic leukemia; he died from suffocation from the rapidly growing tumor in the mediastinum.

53. The High School for Physicians and Patients.—Here Nassauer draws the picture of the lady who goes heavily veiled to the physician's office and complains of heart trouble requiring a thorough examination. It reveals nothing abnormal except possibly a little accelerated heart-beat. A few days later the physician is summoned by telephone early and told to come to her home at 11. He waits till nearly 2, and then apologizes profusely for having been detained. He finds the husband there then and the maids returned from various errands on which they had been sent away in the morning.

Another sketch shows the vagaries of the memory when it comes to paying the physician; the apparent inability of patients to realize or keep count of the number of times they call the physician to their homes; their surprise when they find that it mounts up to such a number of calls when they thought it was only three or four during the whole year at most; the way in which a patient will keep on paying the same small sum which the physician asked years ago, the first time this patient consulted him, when the patient was in almost indigent circumstances. Now that fortune has smiled on her she never thinks of increasing the office fee, and yet, this very patient, in the anteroom is liable to expatiate on the physician's high charges and perhaps drive away some one waiting to consult him but not able to pay the high fees he understands from the woman's remarks are the custom at this office. Nassauer also sketches the richly dressed woman, an old client, and a "very grateful one," as he has saved her life, she realizes, on more than one occasion. At that time she had been an impecunious wage-earner but later married her employer and was now wealthy. Although she often called at his office she never thought of paying him for his services. By keeping up her modest payments to the company in which she had taken out health insurance while employed, she had his services gratis.

Policlinico, Rome

November 16, XX, No. 46, pp. 1657-1692

54 Polymorphous Erythema and Tuberculosis. N. Trulli.

Meditsinskoe Obozrienie, Moscow

LXXX, No. 13, pp. 107-206

55 Diuretic Action of Calcium Chlorid in Nephritis. S. S. Nazimoff.
56 Chorio-Epithelioma. V. S. Baraboshkin.

Hygiea, Stockholm

October, LXXV, No. 10, pp. 993-1104

57 *Hypophysis Extracts in Obstetric Practice. (Hypofysextrakt såsom värkbefordrande medel.) W. Gärdlund.
58 *Vaccination against Chicken-Pox. (Om skyddsympning mot varicellæ.) C. A. Kling.

57. Hypophysis Extract in Obstetric Practice.—Gärdlund concludes from his experience with hypophysis extracts that they may prove useful oxytocics but they cannot always be relied on as the effect seems to depend on the individual response of the uterine musculature. This varies in a wide range. In the extremely susceptible actual tetany of the uterus may be induced.

58. Vaccination against Varicella.—This article is the same as the one reviewed in abstract 36, p. 2277, here accompanied by colored plates showing the positive findings on the arm after vaccination.

Ugeskrift for Læger, Copenhagen

November 6, LXXV, No. 45, pp. 1777-1814

59 *Radiotherapy in Gynecology. A. Maag.
60 Appendix as Sole Content of Femoral Hernia; Two Cases. I. U. Gerdes.

59. Radiotherapy in Gynecology.—Maag reviews a number of articles on this subject and compares the outcome of treatment in over a thousand cases, tabulating further the views of the different authors in regard to indications and contra-indications. His conclusions are in favor of refraining from operative treatment of uterine myoma as Roentgen treatment can cause the myoma to retrogress and the patient does not require hospital care and the treatment is painless. The data presented seem to show also that Roentgen treatment is the sovereign measure for all purely climacteric disturbances.

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JOURNALS INDEXED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT JULY-DECEMBER, 1913

The following journals have been indexed in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers and members in the United States for a period not exceeding three days. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

American Journal of Anatomy. Bi-m. $5. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $3. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Diseases of Women and Children. M. $5. Wood & Co., 51 5th Ave., New York City.
American Journal of Orthopedic Surgery. Q. $3. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.
American Journal of Public Health. M. $2. 289 4th Ave., New York City.
American Journal of Tropical Diseases and Preventive Medicine. M. $2. P. O. Drawer 602, New Orleans, La.
Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.
*Annales de l'Institut Pasteur. M. 20 francs. Paris.
Annales de médecine et chirurgie infantiles. Semi-m. 12 francs. Paris.
Annals of Ophthalmology. Q. $4. Jones H. Parker, Publisher, Mermod-Jaccard Bldg., St. Louis.
Annals of Surgery. M. $5 J. B. Lippincott Co., 227 S. 6th St., Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
*Archiv für Gynäkologie. Irregular. Price varies. Berlin.
*Archiv für Kinderheilkunde. Irregular. 15 marks. Stuttgart.
Archiv für klinische Chirurgie. Irregular. Price varies. Berlin.
Archiv für Verdauungs-Krankheiten. Bi-m. 24 marks. Berlin.
Archives of Diagnosis. Q. $1. 250 W. 73d St., New York City.
Archives générales de chirurgie. M. 26 francs. Paris.
Archives générales de médecine. M. 18 francs. Paris.
Archives of Internal Medicine. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
*Archives internationales de chirurgie. Irregular. 30 francs. Ghent.
*Archives des maladies de l'appareil digestif et de la nutrition. M. 14 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 17 francs. Paris.
*Archives de médecine des enfants. M. 18 francs. Paris.
Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.
Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 27 W. 23d St. New York City.
Archives of Pediatrics. M. $3. E. B. Treat & Co., 241 W. 23d St., New York City.
Australasian Medical Gazette. W. $5. Sydney.
*Beiträge zur Geburtshilfe und Gynaekologie. Irregular. Price varies. Leipsic.
Beiträge zur klinik der Tuberkulose. Irregular. 16 marks. Würzburg.
*Beiträge zur klinischen Chirurgie. M. Price varies. Tübingen.
Berliner klinische Wochenschrift. W. 24 marks. Berlin.
Boston Medical and Surgical Journal. W. $5. 101 Tremont St., Boston.
Brain: A Journal of Neurology. Irregular. $4. London.
Brazil Medico. W. 20 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Bi-m. $3.
British Journal of Children's Diseases. M. $5. London.
British Medical Journal. W. $8.50. London.
Bulletin de l'Académie de médecine. W. 20 francs. Paris.
Bulletin of the American Academy of Medicine. Bi-m. $3. 52 N. 4th St., Easton, Pa.
Bulletin of the Johns Hopkins Hospital. M. $2. Baltimore.
Bulletin of the Lying-In Hospital of the City of New York. Irregular. $1. 23 E. 93d St., New York City.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. $0.25. 1211 Cathedral St., Baltimore.
Bulletin de la Société de pédiatrie de Paris. M. 10 francs. Paris.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Medical Association Journal. M. $5. 145 Wellington St., W. Toronto.
Centralblatt für die Grenzgebiete der Medizin und Chirurgie. Irregular. 22 marks. Jena.
Cleveland Medical Journal. M. $2. 2318 Prospect Ave., Cleveland.
Clinical Journal. W. $4.25. London.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. Tri-m. 18 francs per year. Basel.
Delaware State Medical Journal. M. $1. 309 Shipley St., Wilmington, Del.
Deutsche medizinische Wochenschrift. W. 32 marks. Berlin.
*Deutsche Zeitschrift für Chirurgie. M. Price varies. Leipsic.
*Deutsches Archiv für klinische Medizin. Irregular. Price varies. Leipsic.
Dublin Journal of Medical Science. M. $5.
Edinburgh Medical Journal. M. $6.
Gazzetta degli ospedali e delle cliniche. Tri-w. 25 francs. Milan.
Glasgow Medical Journal. M. $5.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 2.75 kronen. Copenhagen.
Hygiea. M. $5. Stockholm.
Illinois Medical Journal. M. $2. 3338 Ogden Ave., Chicago, Ill.
Indian Medical Gazette. Bi-m. $5. Calcutta.
Jahrbuch für Kinderheilkunde. M. 36 marks. Berlin.
Journal de chirurgie. M. 44 francs. Paris.
Journal de médecine de Bordeaux. W. 15 francs.
Journal d'urologie médicale et chirurgicale. M. 40 francs. Paris.
Journal of Abnormal Psychology. Bi-m. $4. R. G. Badger, 194 Boylston St., Boston.
Journal of the American Medical Association. W. $5. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $1. 810 State Bank Bldg., Little Rock, Ark.
Journal of Biological Chemistry. M. $3. 2419 York Road, Baltimore.
Journal of Cutaneous Diseases. M. $5. Rebman Company, 141 W. 36th St., New York City.
Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York City.
Journal of Hygiene. Q. $5.50. London.
Journal of the Indiana State Medical Association. M. $3. 219 W. Wayne St., Fort Wayne, Ind.
Journal of Infectious Diseases. Q. $5. 57th St. and Greenwood Ave., Chicago.
Journal of Iowa State Medical Society. M. $2. Washington, Ia.
Journal of Kansas Medical Society. M. $2. 501 Husted Bldg., Kansas City, Kan.
Journal of Laryngology, Rhinology and Otology. M. $5. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $1. Harison Bldg., Augusta, Ga.
Journal of Medical Research. M. $4. 240 Longwood Ave., Boston.
Journal of Medical Society of New Jersey. M. $2. 252 Main St., Orange, N. J.
Journal of Michigan State Medical Society. M. $2. 91 Monroe Ave., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3525 Pine St., St. Louis.
Journal of Nervous and Mental Diseases. M. $5. 64 W. 56th St., New York City.
Journal of Obstetrics and Gynecology of the British Empire. M. $6.25. London.
Journal of Oklahoma State Medical Association. M. $2. Muskogee.
Journal of Ophthalmology and Oto-Laryngology. M. $2. 32 N. State St., Chicago.
Journal of Outdoor Life. M. $1. 289 Fourth Ave., New York.

W.—Weekly; M.—Monthly; Semi-m.—Semimonthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

Journal of Pathology and Bacteriology. Q. $5.50. Cambridge, Eng.
Journal of Pharmacology and Experimental Therapeutics. Bi-m. $5. 2419 York Road, Baltimore.
Journal of South Carolina Medical Association. M. $2. Charleston, S. C.
Journal of State Medicine. M. 50 cents. London.
Journal of Tennessee State Medical Association. M. $2. Jackson Bldg., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. $5. London.
Journal-Lancet. Semi-m. $2. 839 Lumber Exchange, Minneapolis.
Kentucky Medical Journal. Semi-m. $2. Atherton Bldg., Bowling Green, Ky.
Lancet. W. $8. London.
Laryngoscope. M. $5. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. W. 20 francs.
Maryland Medical Journal. M. $2. Professional Bldg., Baltimore.
Medical Press and Circular. W. $5. London.
Medical Record. W. $5. W. Wood & Co., 51 5th Ave., New York City.
Meditsinskoe Obozrienie. Semi-m. 10 rubles. Moscow.
Medizinische Klinik. W. 32 marks. Berlin.
Military Surgeon. M. $3.50. 535 N. Dearborn St., Chicago.
Mississippi Medical Monthly. M. $1. 506 First National Bank Bldg., Vicksburg, Miss.
Mitteilungen aus den Grenzgebieten der Medizin und Chirurgie. Irregular. 25 marks. Jena.
Modern Hospital. M. $3. Monroe Bldg., Chicago.
*Monatsschrift für Geburtshülfe und Gynäkologie. M. 42 marks. Berlin.
*Monatsschrift für Kinderheilkunde. M. 20 marks. Leipsic.
Münchener medizinische Wochenschrift. W. 32 marks. Munich.
Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
New Mexico Medical Journal. M. $2. P. O. 23, Las Cruces, N. M.
New Orleans Medical and Surgical Journal. M. $2. 1551 Canal St., New Orleans.
New York Medical Journal. W. $5. A. R. Elliott Publishing Co., 66 W. Broadway, New York City.
New York State Journal of Medicine. M. $1. 17 W. 43d St., New York City.
*Nordiskt Medicinisk Arkiv. Irregular. 30 marks. Stockholm.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
Ohio State Medical Journal. M. $2. 207 E. State St., Columbus, Ohio.
Old Dominion Journal of Medicine and Surgery. M. $2. 116 E. Franklin St., Richmond, Va.
Ophthalmic Record. M. $4. 7 W. Madison St., Chicago.
Ophthalmology Q. $5. 711-714 Cobb Bldg., Seattle, Wash.
Pediatria. M. 6 rubles. St. Petersburg.
Pennsylvania Medical Journal. M. $2. Athens, Pa.
Philippine Journal of Science. Irregular. $7. Manila, P. I.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Presse médicale. Semi-w. 15 francs. Paris.
Public Health Journal. M. $2. York Publishing Co., Lumsden Bldg., Toronto.
Quarterly Journal of Medicine. $6.50. London.
Revue de chirurgie. M. 33 francs. Paris.
*Revue de gynécologie. M. 30 francs. Paris.
*Revue de médecine. M. 23 francs. Paris.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Revue mensuelle de gynécologie, d'obstétrique et de pédiatrie. M. 12 francs. Paris.
Revue pratique d'obstétrique et de gynécologie. M. 8 francs. Paris.
Riforma medica. W. 35.50 lire. Naples.
Rivista Ospedaliera. Semi-m. 20 lire. Rome.
St. Petersburger medizinische Zeitschrift. Semi-m. 14 marks. St. Petersburg.
Sei-I-Kwai. M. $2. Tokyo.
Semaine médicale. W. 15 francs. Paris.
Semana médica. W. $5. Buenos Aires.
Southern Medical Journal. M. $2. 905 Van Antwerp Bldg., Mobile, Ala.
Surgery, Gynecology and Obstetrics. M. $5. Surgical Publishing Co., 31 N. State St., Chicago.
Surgery, Gynecology and Obstetrics with International Abstract of Surgery. M. $10. Surgical Publishing Co., 31 N. State St., Chicago.
Texas Medical Journal. M. $1.50. Western National Bank Bldg., Fort Worth Texas.
Therapeutische Monatshefte. M. 12 marks. Berlin.
Therapie der Gegenwart. M. 14 marks. Berlin.
Tumori. Bi-m. 25 lire. Rome.
Ugeskrift for Læger. W. 20 kr. Copenhagen.
United States Naval Medical Bulletin. Q. $1. Washington, D. C.
Upsala Läkareförenings Förhandlingar. Irregular. 10 kr.
Vermont Medical Monthly. M. $1. Burlington Medical Publishing Co., Burlington, Vt.
*Virchows Archiv für pathologische Anatomie und Physiologie und für klinische Medizin. M. 16 marks. Berlin.
Washington Medical Annals. Bi-m. $1. 2114 18th St., N.-W., Washington, D. C.
West Virginia Medical Journal. M. $1. Wheeling, W. Va.
Wiener klinische Wochenschrift. W. 24 marks. Vienna.
Wisconsin Medical Journal. M. $2. Goldsmith Bldg., Milwaukee
*Zeitschrift für Geburtshülfe und Gynaekologie. Irregular. Price varies. Stuttgart.
*Zeitschrift für Kinderheilkunde. Irregular. 18 marks. Berlin.
*Zeitschrift für klinische Medizin. Irregular. 16 marks. Berlin.
*Zeitschrift für Urologie. M. 30 marks. Berlin.
Zentralblatt für Chirurgie. W. 30 marks. Leipsic.
Zentralblatt für Gynäkologie. W. 30 marks. Leipsic.
Zentralblatt für innere Medizin. W. 30 marks. Leipsic.

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FOREIGN EXCHANGES WHICH CAN BE LENT†

Annales de dermatologie et de syphiligraphie. M. 32 francs. Paris.
Annali dell' Istituto Maragliano. Irregular. 15 lire. Genoa.
Archives internationales de laryngologie, d'otologie et de rhinologie. Bi-m. 22 francs. Paris.
Bulletin de la Société française de dermatologie et de syphiligraphie. Semi-m. 17 francs. Paris.
Bulletins de la Société médicale des hôpitaux. W. 28 francs. Paris.
Bulletins de la Société de radiologie médicale de Paris. M. 22 francs. Paris.
Crónica médica. Semi-m. 15 francs. Lima, Peru.
Crónica médica méxicana. M. 2.00 oro. Mexico.
Dermatologische Wochenschrift. M. 24 marks. Hamburg.
Gazette médicale belge. W. 7 francs. Liége.
Ginecologia. Bi-m. 15 lire. Florence.
Internationales Centralblatt für die gesamte Tuberkulose-Forschung. M. 20 marks. Würzburg.
Janus. M. $5.00. Leyden.
Pediatria Española. M. 12 francs. Madrid.
Prager medizinische Wochenschrift. W. 17 K. Prague.
Prensa médica. M. Havana.
Progrès médical. W. 12 francs. Paris.
Revista de medicina y cirugia. Semi-m. $4.50. Havana.
Revista medica Cubana. M. Havana.
Rivista di patologia nervosa e mentale. M. 30 lire. Florence.
Russkiy Vrach. W. 13 rubles. St. Petersburg.
Siglo médico. W. 20 pesetas. Madrid.
Tidsskrift for den norske Lægeförening. Semi-m. 15 kronen. Christiania.
Wiener klinische Rundschau. W. 30 francs. Vienna.

† These journals are not indexed in the Current Medical Literature Department of THE JOURNAL, but may be borrowed under the usual conditions.

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EXPLANATION OF THE USE OF THE INDEX

This is an index not only to the reading matter in THE JOURNAL, but also to original articles in the principal medical periodicals of this and other countries. The reading matter appearing in THE JOURNAL is distinguished by the use of **black-faced numerals.**

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "Ml," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

This is a subject index and one should, therefore, look for the chief word, with the following exceptions: "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "D" and "S." Matter pertaining to the Association is indexed under "American Medical Association."

All matter is indexed under the most important word of the heading used in THE JOURNAL, and also under the subject heading. For instance, abscess of the brain will be found under "abscess," as well as under "brain." Such titles as "ocular manifestations, etc." have been indexed under "Eye." Cross references have been liberally used.

The figures in parentheses refer to the paragraph, the number following to the page in THE JOURNAL.

ABSCESS, temporosphenoidal, with meningeal symptoms, *1209

This reference is to an original article in THE JOURNAL, as shown both by the star and by the black-faced numerals indicating the page.

AARON and Rosenbach signs for appendicitis, 2001

This reference, as indicated by the black-faced figures, is also in THE JOURNAL, and on turning to page 2001 we find an answer to a question in the Department of Queries and Minor Notes.

ABSCESS, liver, emetine in (5) 1936

In this reference, the (5) indicates that the article is in the Current Literature Department and the fact that the page number is in black-faced type shows that the article is abstracted and discussed in THE JOURNAL. Turning to page 1936, we find (5) refers to an article by R. L. Spittel in the *British Medical Journal*, October 25.

ABBOTT'S method of treating scoliosis, (104) 513

The fact that in this last reference the page is given in ordinary type indicates that only the title of the article is given. Turning to page 513 we find that the numeral (104) refers to a paper on that subject by S. Kleinberg which appeared in *Surgery, Gynecology and Obstetrics*, July.

In the AUTHOR'S INDEX are the names of the authors of articles which have appeared in THE JOURNAL of the American Medical Association and of articles that have been listed from week to week in the Department of Current Medical Literature as having appeared in other journals. The black-faced numerals indicate that the article is in THE JOURNAL, either in full or in abstract. The star (*) preceding the page number, indicates an original article.

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SOCIETIES

A.—Association.
Acad.—Academy.
Am.—America, American.
Coll.—College.
Conf.—Conference.
Cong.—Congress.
Conv.—Convention.
Dist.—District.
Hosp.—Hospital.
Internat.—International.
M.—Medical, Medicine.
Nat.—National.
Pharm.—Pharmaceutical.
Phys.—Physicians.
Ry.—Railway.
S.—Society.
Surg.—Surgical, Surgery, Surgeons.

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